DELAWARE STATE MEDICAL JOURNAL

INCORPORATED 1789

DECEMBER, 1959

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and your happy New Years,
your long lives and your true prosperities.
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Charles Dickens, "Dr. Marigold's Prescriptions"

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INCORPORATED 1789

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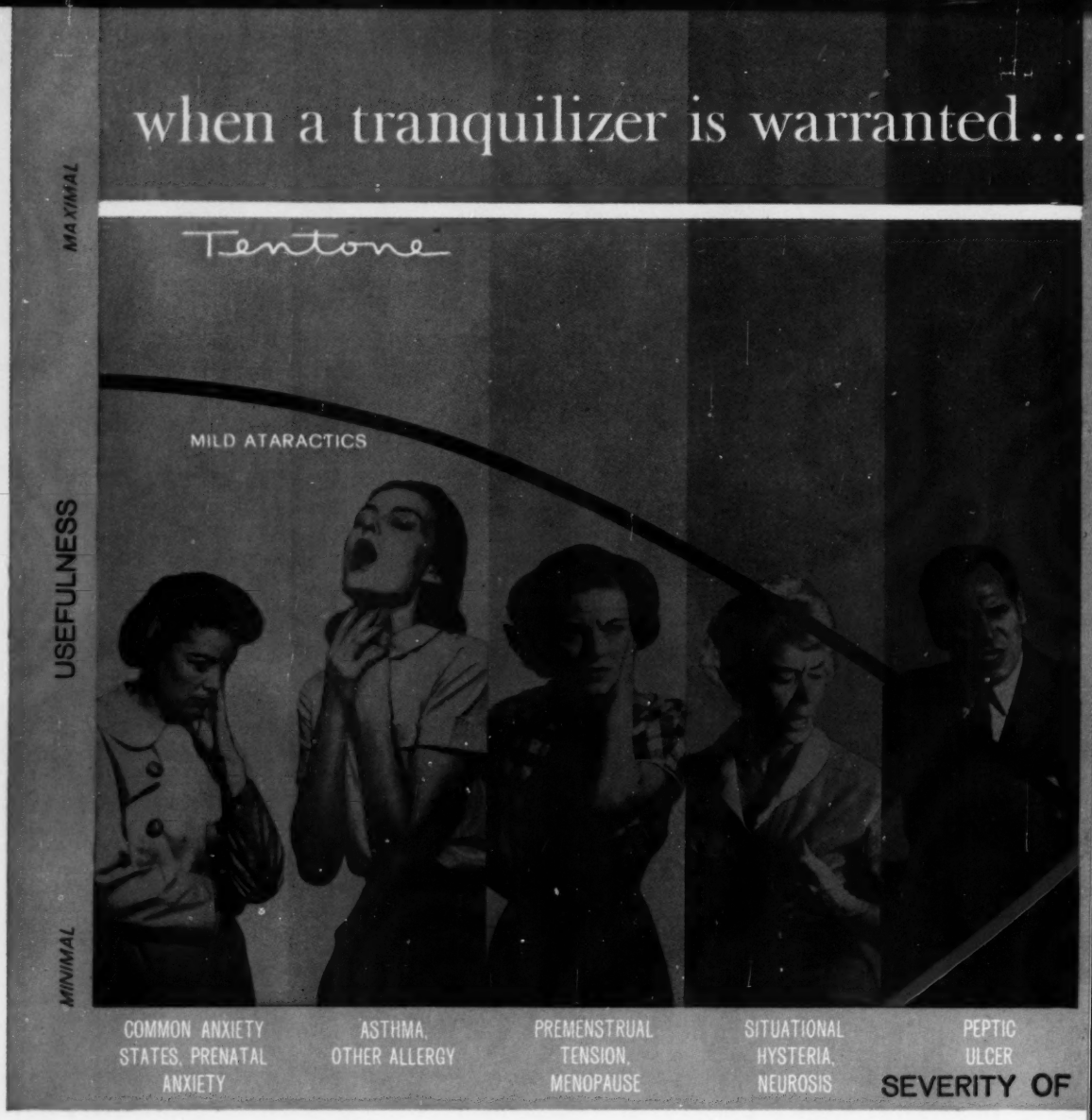

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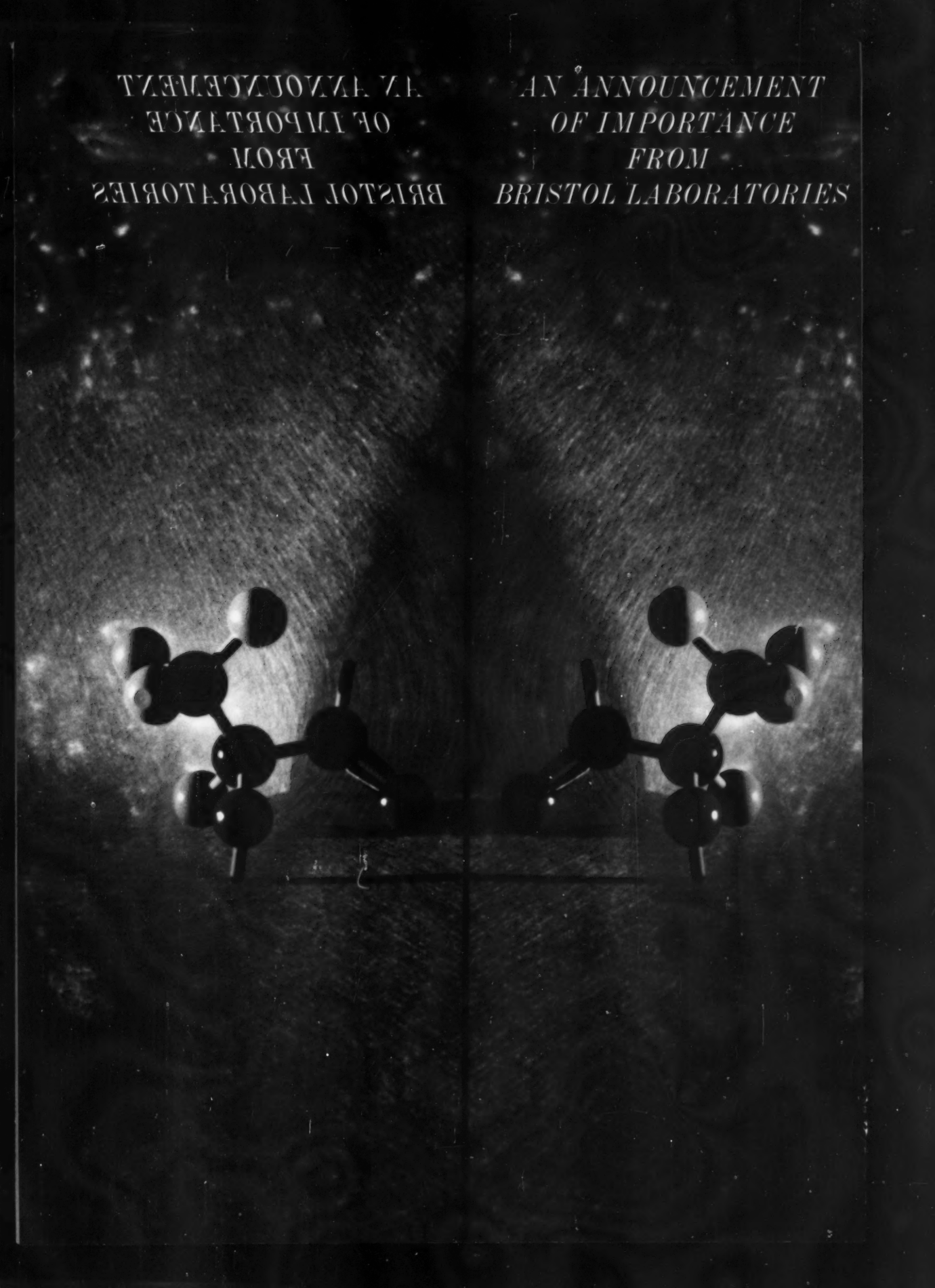

The first synthetic penicillin available for general clinical use

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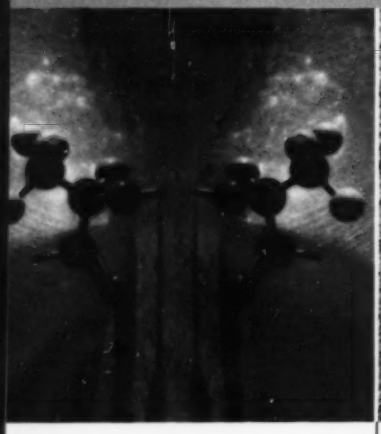

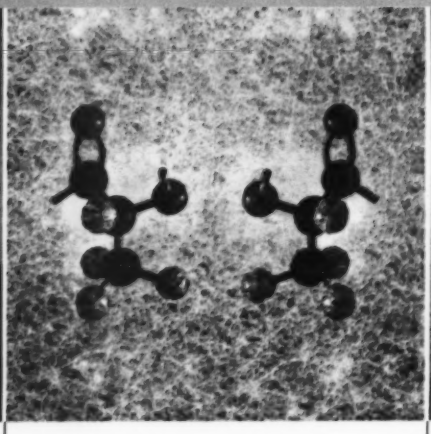

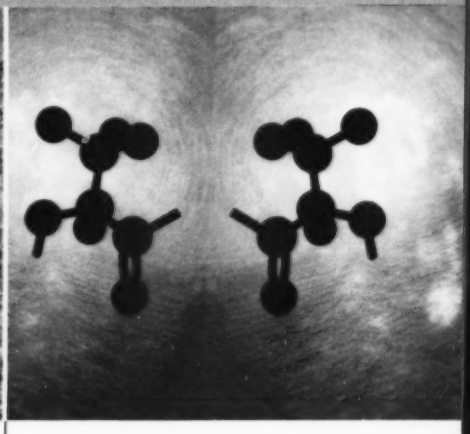

BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

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ORIGIN OF A NEW

ADVANTAGES ACCOMPANY MOLECULAR ASYMMETRY

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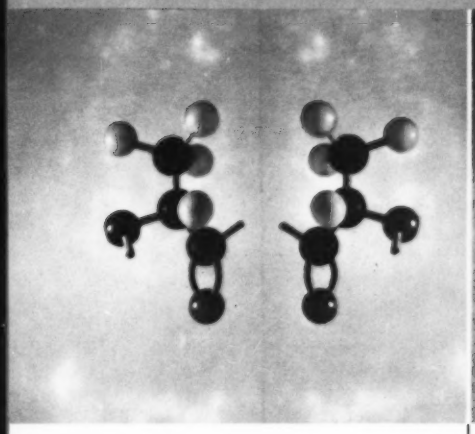
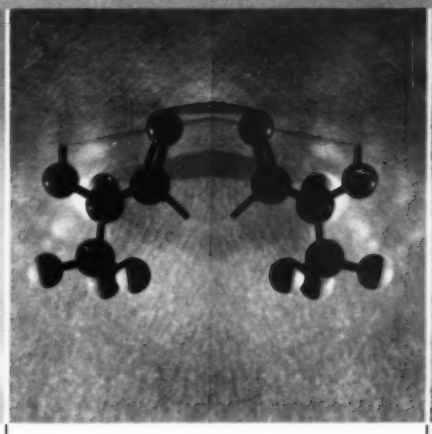
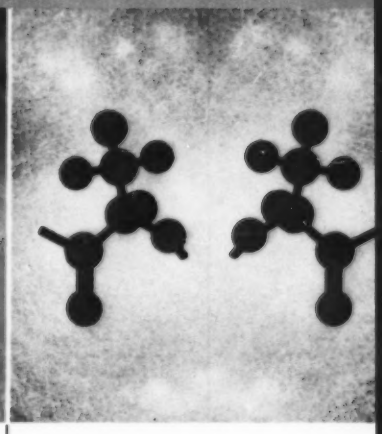
POTASSIUM PENICILLIN-152







ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN

BRISTOL

ISOMERIC COMPLEMENTARITY

ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

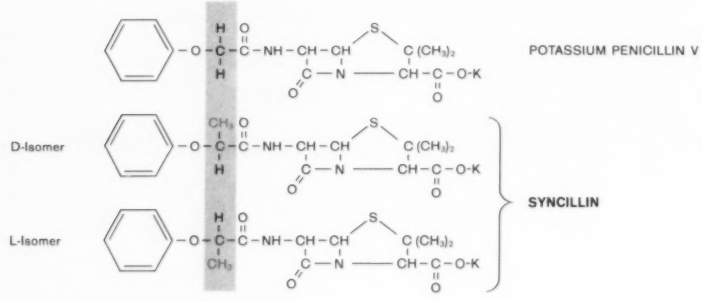
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

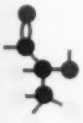
SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.





SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

ISOMERIC COMPLEMENTARITY

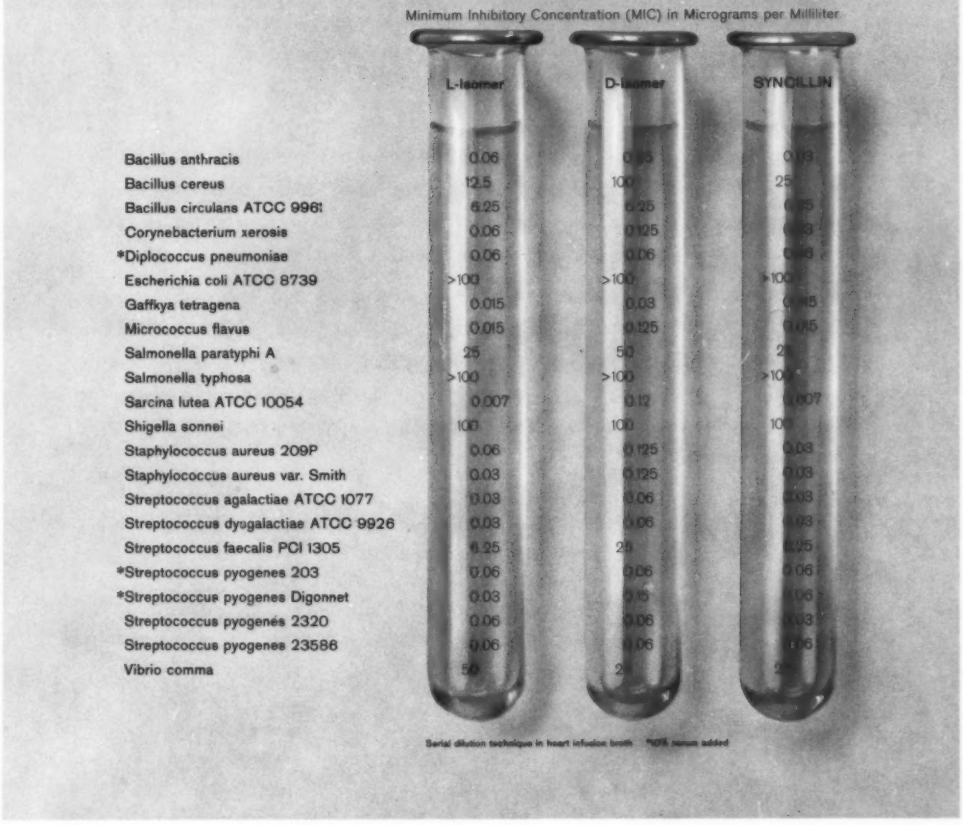
ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli*, and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria



SYNCILLIN

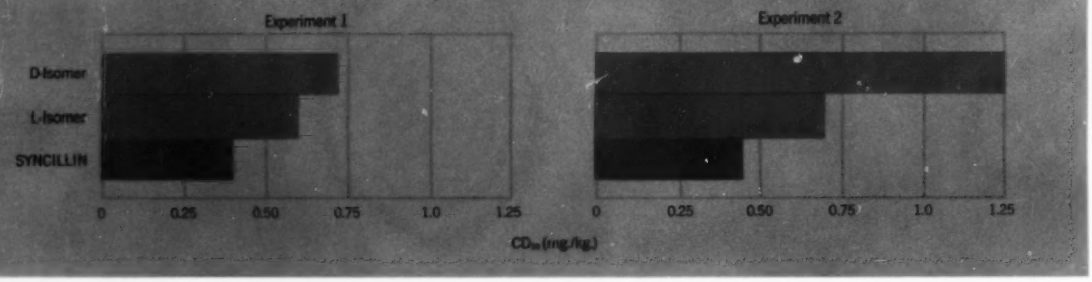
major therapeutic advantages accompany molecular asymmetry

Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci

ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

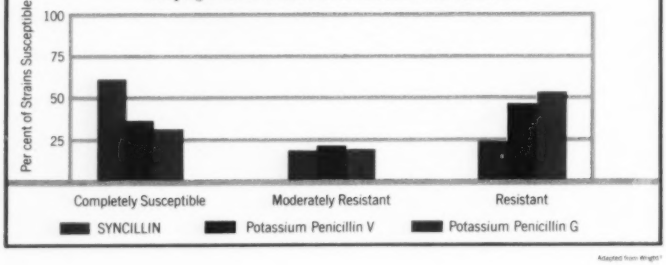


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 – *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources



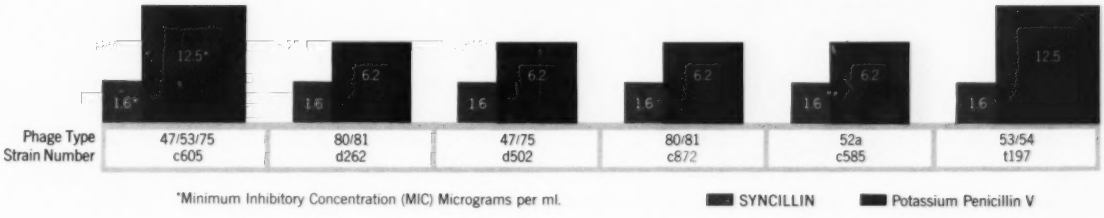
Adapted from Wright[2]

ISOMERIC COMPLEMENTARITY

Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit
Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

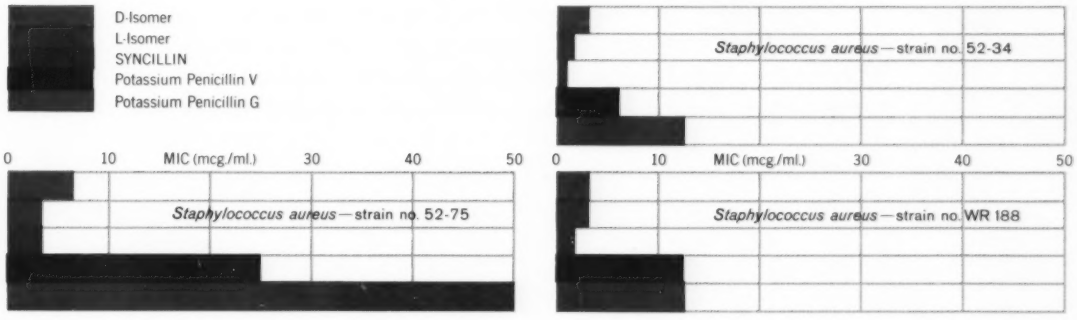


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive
Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

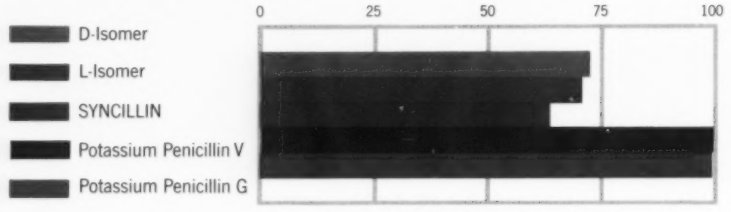
BLOOD LEVELS TWICE AS HIGH AS WITH

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

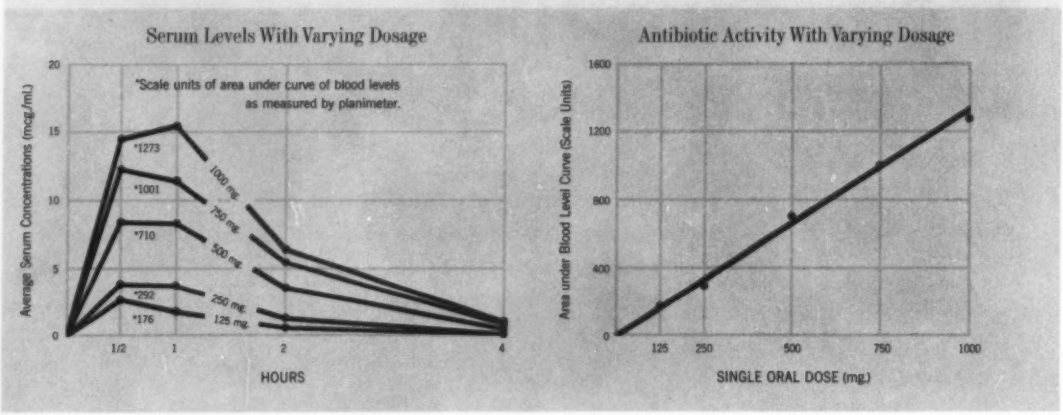
FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins

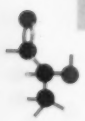


ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6





SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

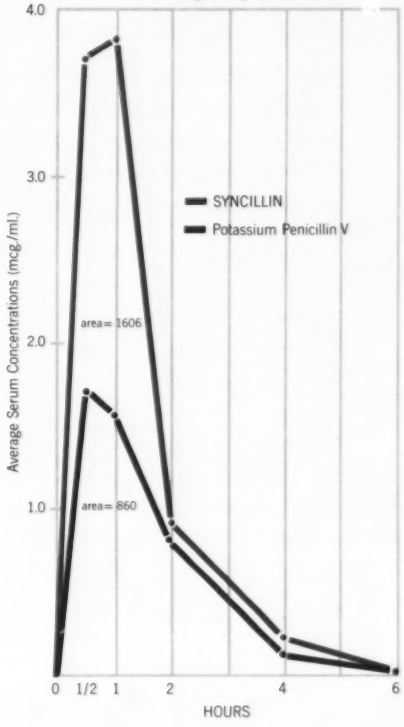
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

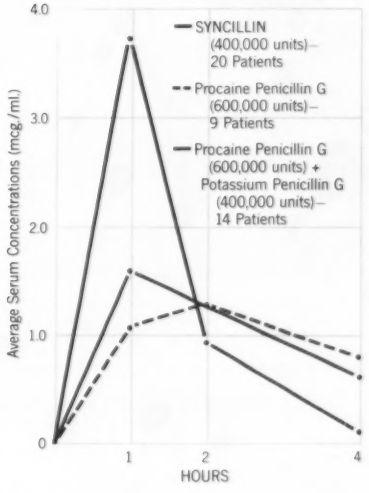
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal,* these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

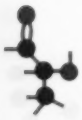
As Flippin[9] recently stated, ". . . it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted. . . . In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

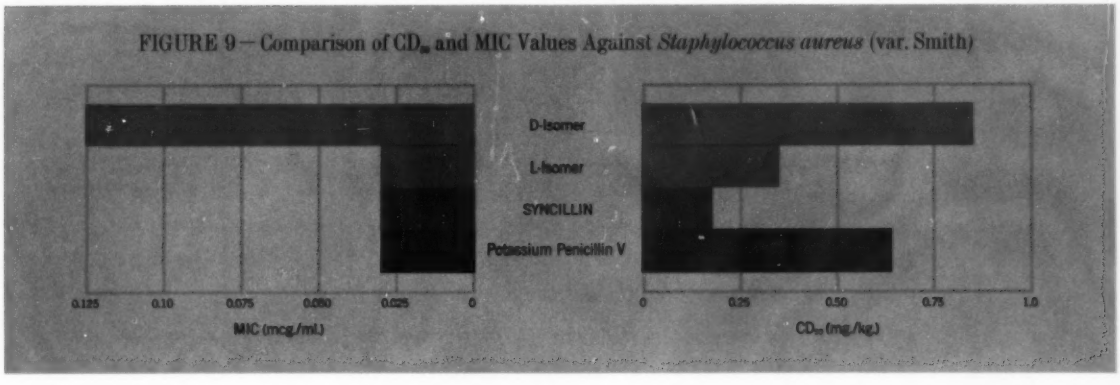


FIGURE 9 — Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)

Isomeric complementarity has thus been demonstrated for:

— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

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brand of oxytetracycline

INTRAMUSCULAR SOLUTION

Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

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oxytetracycline with glucosamine

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

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Cosa-Terramycin is also available as:
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Cosa-Terramycin Pediatric Drops — peach flavored, 5 mg./drop (100 mg./cc.), 10 cc. bottle with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

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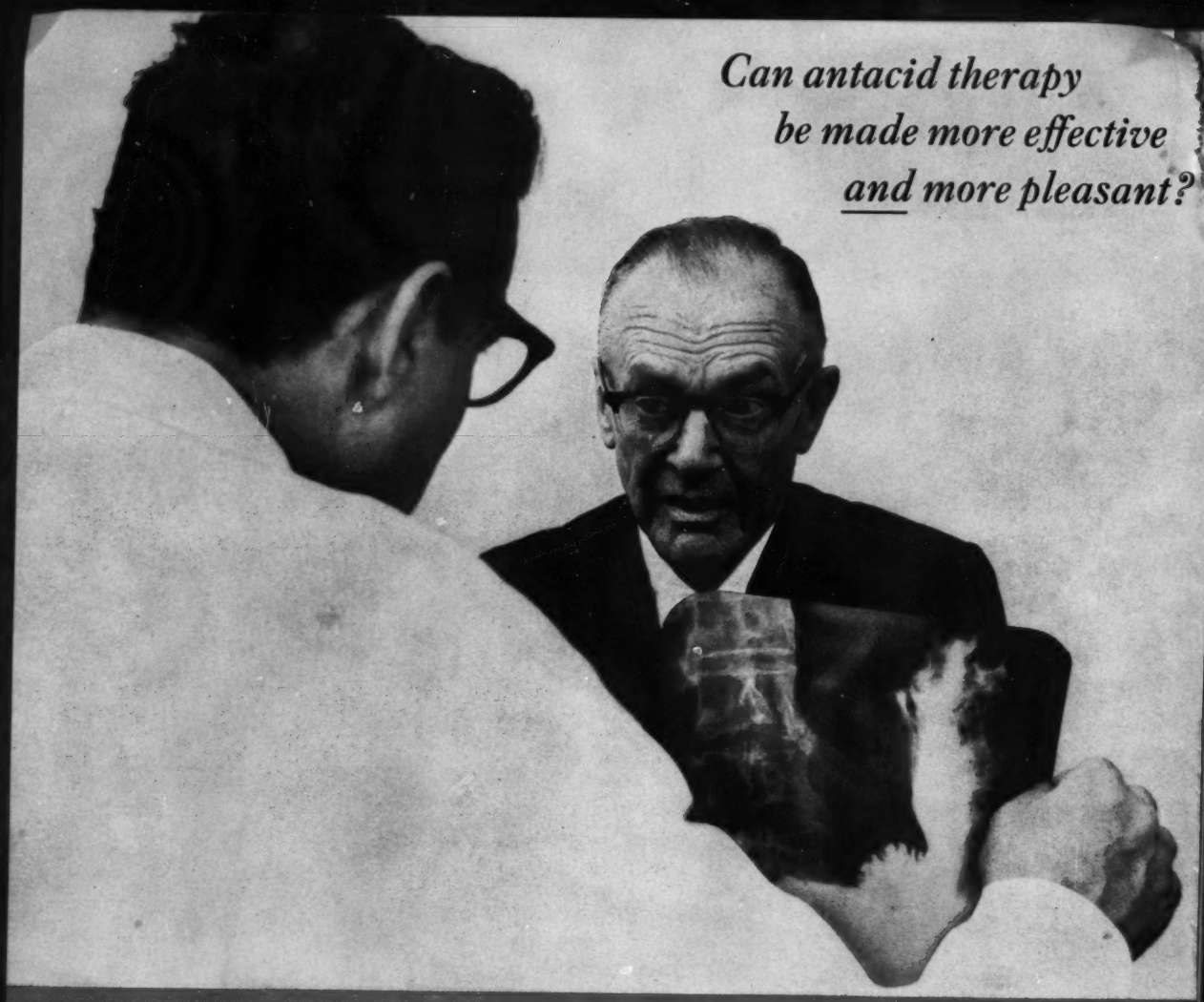

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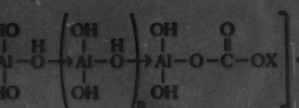

n is at least 1 and averages less than 6. X is a cation.

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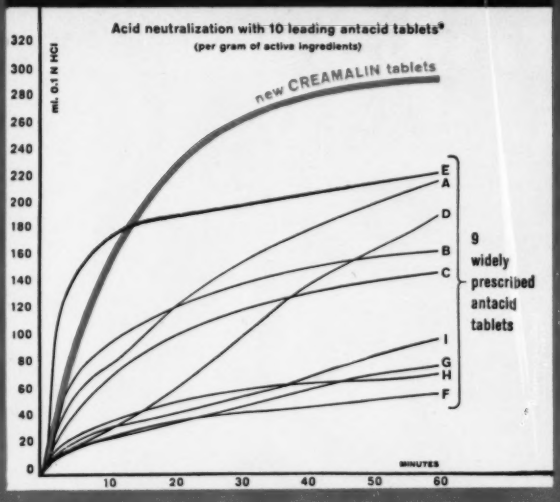
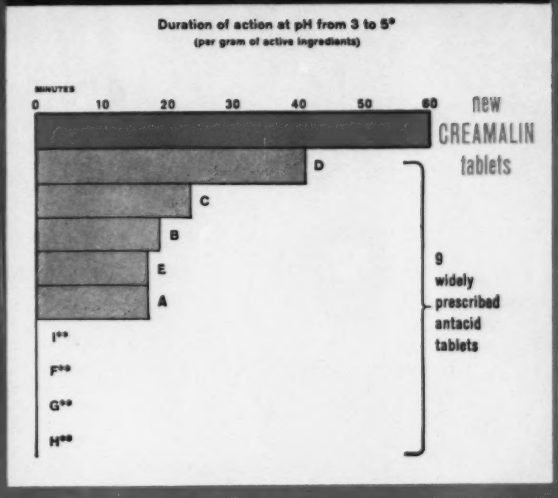
Quicker Relief • Greater Relief



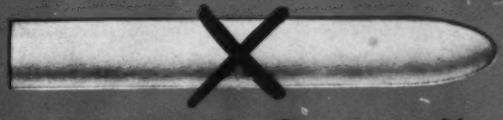
Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

CREAMALIN NEUTRALIZES *MORE* ACID *LONGER*

More Lasting Relief



*Hinkal, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

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greater specificity
of tranquilizing action
—divorced from such
"diffuse" effects as
anti-emetic action
—explains why

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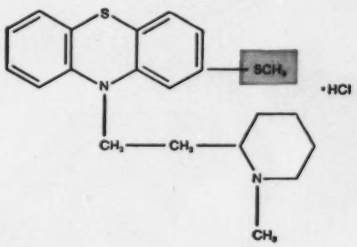
THIORIDAZINE HCl

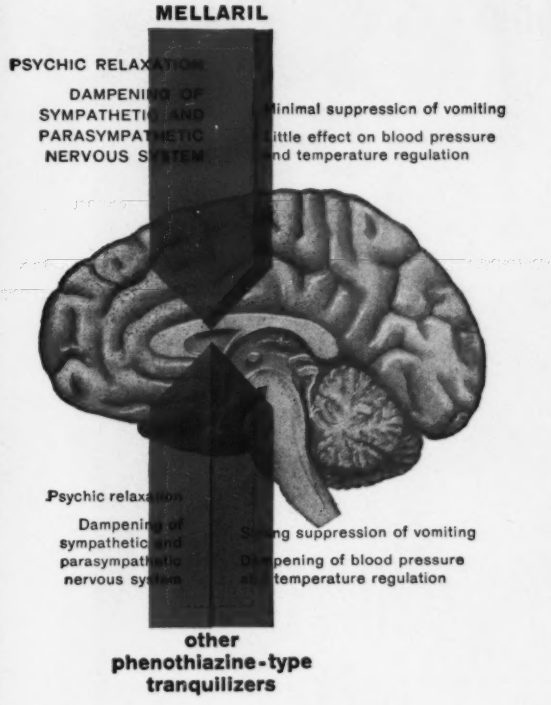
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

a new advance in tranquilization:
greater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S-CH_3) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

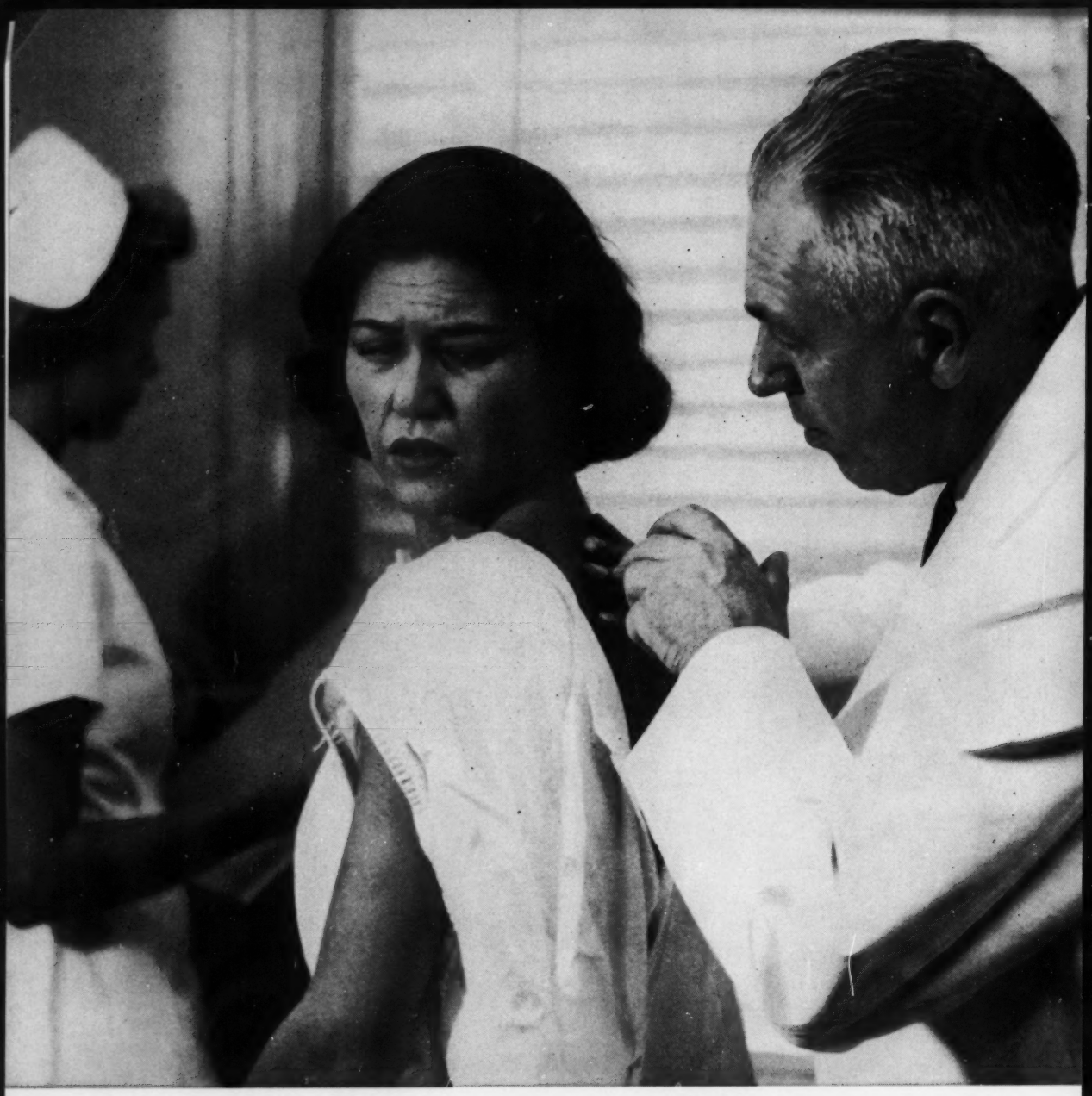
5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ



"I feel tired even after a full night's sleep."

Restores normal vitality in

emotional fatigue

Deprol relieves undue tiredness, apathy and depressed moods as it calms anxiety – without the risk of liver damage or extrapyramidal symptoms frequently reported with energizers or phenothiazines.

Emotional or nervous fatigue—undue tiredness, apathy, lethargy and listlessness—cuts sharply into the patient's usual physical and mental productivity. It is one of the most common conditions seen in every medical practice. Untreated, emotional fatigue may mushroom into a depressive episode, anxiety state, chronic fatigue or a mixture of these disorders.

Deprol acts fast to relieve emotional fatigue. It overcomes tiredness and lethargy, apathy and listlessness, thus restoring normal vitality and interest before the fatigue deepens. On Deprol, improvement is achieved without producing liver toxicity, hypotension, psychotic reactions, changes in sexual function or Parkinson-like reactions associated with energizers or phenothiazines.

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and

11. Laughlin, H. P.: The Neuroses in Clinical Practice, Saunders, Philadelphia, 1956, pp. 448-481.

▲Deprol▲®

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets.

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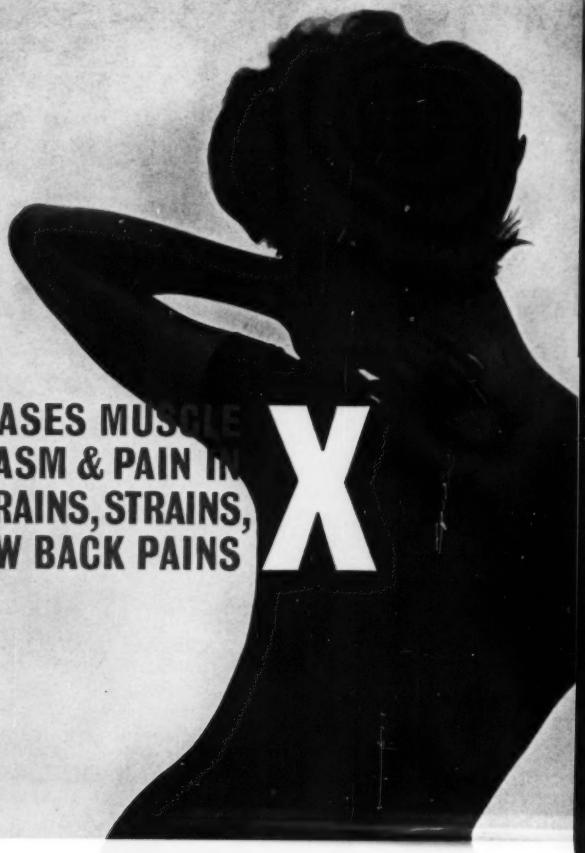

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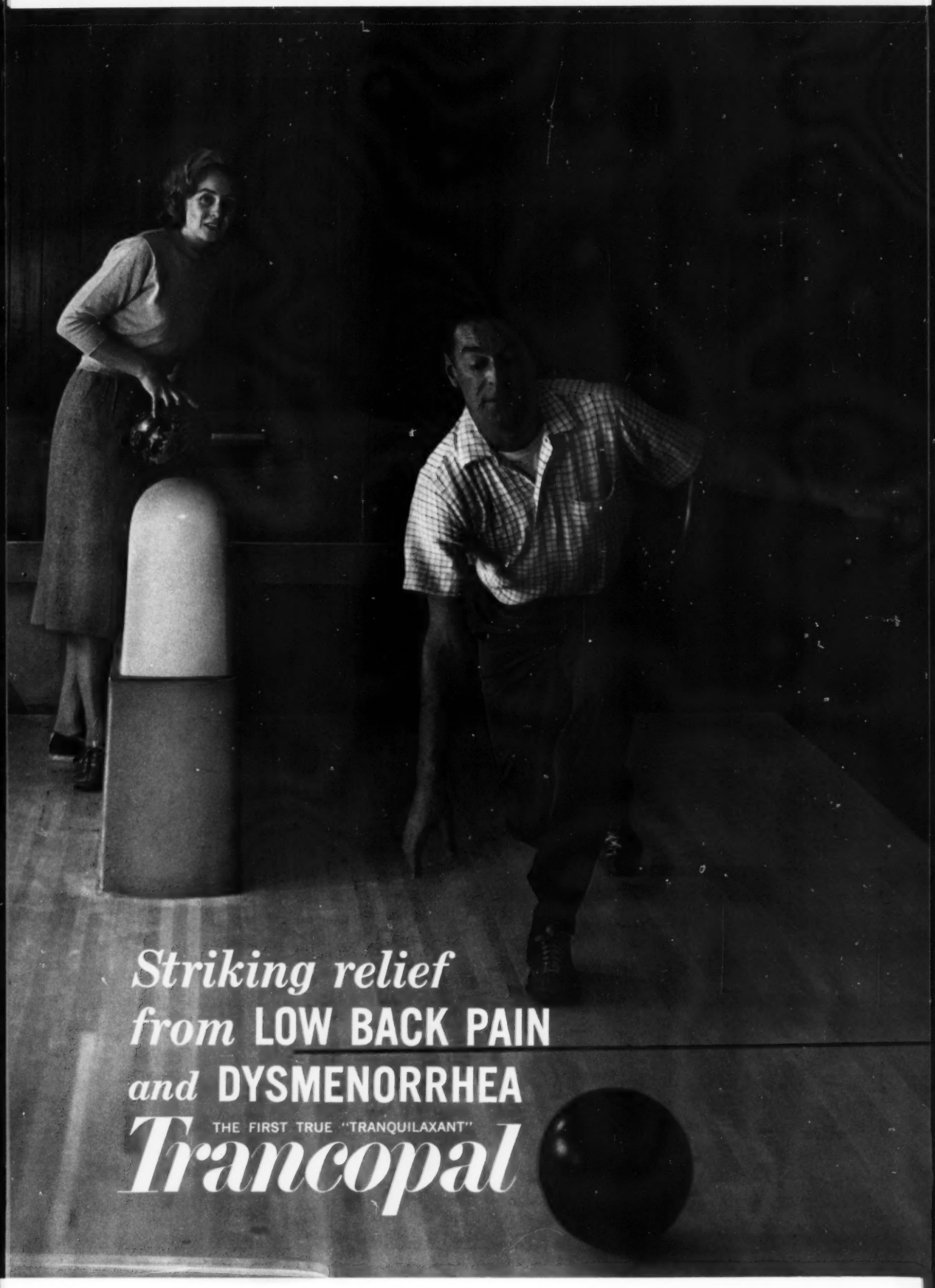
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from LOW BACK PAIN
and DYSMENORRHEA
THE FIRST TRUE "TRANQUILAXANT"
Trancopal

Here is what you can expect when you prescribe

for dysmenorrhea

and premenstrual tension

Case Profile*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.

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Trancopal

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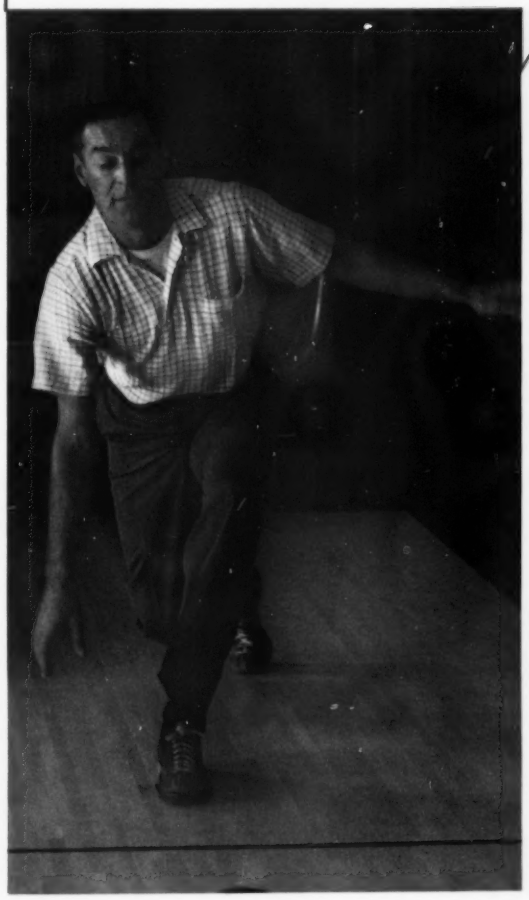
Trancopal®

for low back pain



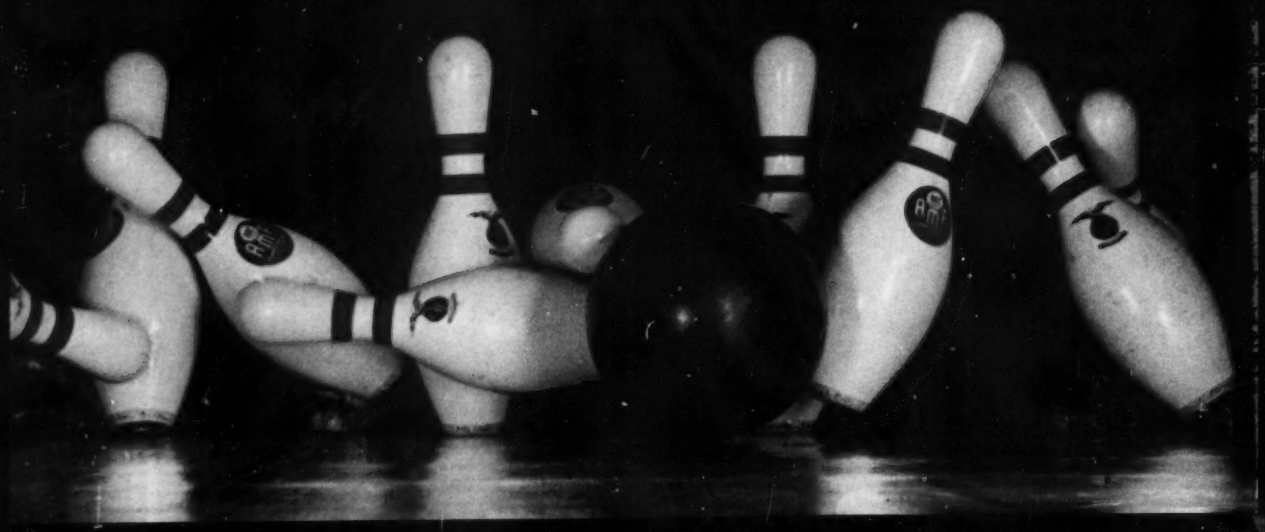
Case Profile*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

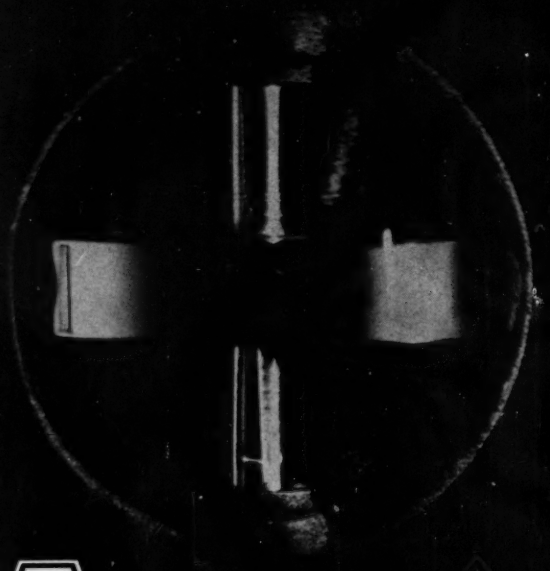
For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.



minimal disturbance
of the patient's chemical and psychic balance...



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Substantiated by published reports of leading clinicians:

- **effective control** of allergic and inflammatory symptoms[1-20]
- **minimal disturbance** of the patient's chemical and psychic balance[1, 4, 5, 8-19]

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Triamcinolone LEDERLE

At anti-inflammatory and antiallergic levels ARISTOCORT means:

- **freedom from salt and water retention**
- **virtual freedom from potassium depletion**
- **negligible calcium depletion**
- **euphoria and depression rare**
- **no voracious appetite—no excessive weight gain**
- **low incidence of peptic ulcer**
- **low incidence of osteoporosis with compression fracture**

Indications: rheumatoid arthritis; arthritis; respiratory allergies; allergic and inflammatory dermatoses; disseminated lupus erythematosus; nephrotic syndrome; lymphomas and leukemias.
Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms. After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually.
Supplied: Scored tablets of 1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).
Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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VISTARIL has an outstanding record of safety and is valuable adjunctive therapy in home or hospital when administered to patients with peptic ulcer, gastroenteritis, esophageal spasm, and nervous dyspepsia.

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DELAWARE STATE MEDICAL JOURNAL

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VOLUME 31 DECEMBER, 1959 NUMBER 12

ADDRESS OF THE PRESIDENT

AT ANNUAL MEETING OF THE MEDICAL SOCIETY OF DELAWARE OCTOBER 15, 1959

A. R. SHANDS, JR., M.D.

It has been said that the true physician studies the past, evaluates the present, and plans the future. With this thought in mind, your speaker will first say a word about our past, for without the past some say that "man's soul is purblind, seeing only the things which almost touch his eyes."

On the occasion of the 150th anniversary of the founding of the Medical Society of Delaware, there was published an excellent and detailed book titled, *A Brief History of the Medical Society of Delaware*, 1789-1939, written by its president, Dr. Meredith I. Samuel. This is by far the best account we have of our past. I have re-read this carefully in the preparation for this address and cannot help but feel in reading this a sense of pride in the history of our Society and a deep sense of appreciation to Dr. Samuel for the many long hours he spent in so carefully recording our heritage.

The leader of the twenty-seven physicians who acted as incorporators of the Medical Society of Delaware in 1789, undoubtedly physicians who "cultivated" medicine of that day "with ardour and diligence," as mentioned in the Act of Incorporation, was none other than James Tilton, born in Kent County in 1745, but living most of his life in Wilmington. He was elected the first president and remained so for thirty-three years, until he died in 1822 at the age of seventy-seven. Dr. Tilton was not only the most outstanding doctor in Delaware in his day, but also was considered by many to be one of the three great physicians in the thirteen original States; the other two being the renowned teacher, Benjamin Rush of Philadelphia, and the well-known John Warren of Boston. One of the finest compliments paid Dr. Tilton was by George Washington who spoke of him as "a gentleman of great merit." In the Revolutionary

War he was in charge of four hospitals located at Princeton and Trenton, New Jersey; New Windsor, Maryland, and Williamsburg, Virginia; and in these hospitals he established isolation wards for contagious diseases, the first ever to be opened in any hospital. During the war he declined a professorship at the University of Pennsylvania School of Medicine, the first and foremost medical school of our new country, an indication of the esteem in which he was held by his alma mater from which he graduated in 1771. He wrote an excellent book on military medicine and probably on account of this was asked to be the first surgeon general of the United States Army, being appointed during the War of 1812 and occupying this position from 1813 to 1815. James Tilton is the number one physician in Delaware's Medical Hall of Fame and in the Brandywine Cemetery is a beautiful monument to his memory, erected by the Medical Society of Delaware. So, first, in this address I, as the 108th president, wish to salute and pay tribute to the greatest of the greats in our past, our first president, James Tilton.

With the incorporation of our Medical Society, it became the third State Medical Society in the United States, the first being New Jersey, organized in 1766, and the second Massachusetts. By 1800, seven of the thirteen states had societies. Tilton was succeeded in the presidency of our Society by James Sykes, who, twenty-one years before, had been the Governor of Delaware. In the early days of the Society many of the presidents succeeded themselves or were re-elected after a period of years. One of these was James Couper, Jr., president from 1835 to 1841, again from 1843 to 1845, and, finally, twenty years later in 1864-65. In 1863 he was a vice-president of the American Medical Association. The only Delaware doctor to have been president of the American Medical Association is Henry Ford Askew, who was president of our Society on two occasions—from 1851 to 1855 and, then, 1875 to 1876. He was president of the AMA in 1867 and, incidentally, was the founder and first president of the Historical Society of Delaware in 1873. At the time that Dr. Askew was president of the AMA, a doctor was Governor of the state of Delaware, the Honorable Gove Saulsbury, who had been the president of our Society from 1861 to 1862.

In 1863 the Sussex County Society was organized. This was our first County Society. The New Castle County Society was not organized until 1901, and the Kent County Society in 1916. It is rather interesting to me, an orthopaedic surgeon, that during the War Between the States, a Delaware physician and Union Army surgeon, Dr. William Marshall, of Sussex County, president from 1869 to 1870, performed the first successful resection of a humerus. In his early medical career, Dr. Marshall went to California in the Gold Rush Days of 1849 and was at one time both the sheriff and doctor of Hangtown, California, an unusual name for a town as well as an unusual combination of vocations. William Marshall's son George was a prominent leader in the Republican Party in Lower Delaware and became the insurance commissioner as well as ex-officio banking commissioner of Delaware. He was president in 1886-87, and two of his sons were prominent in Sussex County medicine many years later.

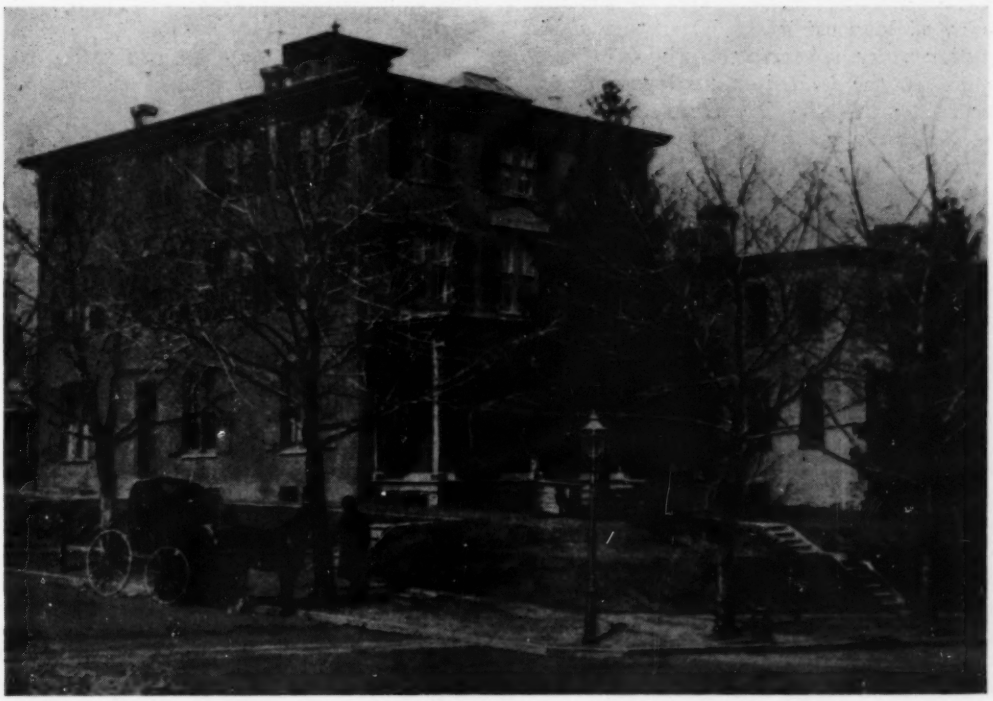
Dr. Ezekiel Dawson, president, 1880-1881, and an unusual English scholar, wrote a very thought-provoking presidential address. Among the many things he said was the following: "I deem it to be the duty of every physician as far as opportunity avails, to aid in developing the science of his choice. No one ought to be willing after adopting such a noble calling to plod along an old beaten track of routineism, nor to run the wheel of his energies in a muddy rut of self-sufficiency." It is certainly most appropriate to say that every physician should aid in the developing of the science of his choice, but how many of us do? Being in a "track of routineism" or getting into a "muddy rut of self-sufficiency" may be due to intellectual laziness and this should not be a difficult situation to remedy

with the many opportunities we have today for graduate education. But there must be a "will-to-do," to come out of this "track" and "rut," a something which every one must discover within himself.

We find in our past that eighty years ago a State Board of Health was established by Act of Legislature on March 13, 1879, a memorable occasion for the state. Fifty years ago the Delaware State Medical Journal was founded. Dr. William Edwin Bird was the editor of this Journal for forty years (1916-1956), and to him our Society owes a great debt of gratitude, for he not only put our Journal on a firm footing but also ran the Society as secretary for eight years. When he died in 1956, he was the oldest editor from the standpoint of service of all the editors of State Medical Journals.

The present Delaware State Hospital at Farnhurst was opened seventy years ago in 1889; however, over a century before in 1785, its predecessor in the form of a County Almshouse, had been opened in Wilmington. Fifty-eight years later in 1843, a special building was erected in connection with the County Almshouse to house the insane. In 1848 a small hospital was built adjacent to these buildings for sick immigrants. It was used to receive smallpox patients during the epidemics and it is sometimes referred to as the "Smallpox Hospital." The first general hospital was a military one; it was a frame building with 350 beds and was built in 1863 in Wilmington at 10th and West Streets by the Delaware Association for the Sick & Wounded Soldiers. It was fittingly called the Tilton Hospital. Appropriately enough in the last war one of the finest of the Army hospitals was the Tilton General Hospital at Fort Dix, New Jersey.

In 1871 Heald's Hygeian Home was opened by Drs. Pusey and Mary Heald at



The nucleus of the Wilmington Memorial Hospital was known in 1871 as Heald's Hygeian Home, a private health institution situated at Shallcross Avenue and Van Buren Street, Wilmington.

Shallcross Avenue and Van Buren Street and ran as a private health institution for fifteen years. It is stated that over 7,000 patients were treated from every state in the Union and many foreign countries—quite a record. In 1888 Heald's Home was bought by a group of women interested in homeopathic medicine and opened as the Homeopathic Hospital; the name being changed in 1940 to the Memorial Hospital. Two years later in February, 1890, the Delaware Hospital opened. The Wilmington General Hospital first admitted patients in 1909, the Beebe Hospital in 1916, the St. Francis Hospital in 1924, the Kent General in 1927, the Milford Hospital in 1938, and the Nanticoke in 1945. In addition the Veterans Administration Hospital was established in 1946 in the old New Castle Army Air Force Hospital at the Air Base of this name; it moved into its present new building in 1950.

It is surprising that there is no record of a medical school in Delaware, when a state such as Missouri in the latter part of the 19th century had forty-two schools of medicine. In the United States between 1872 and 1890, the incredible number of 114 new schools were established. In the early days most of the physicians of Delaware were educated in Philadelphia, particularly at the University of Pennsylvania, where medical education was at its best. So, with these few remarks from our past, the heritage of which we should always hold dear, next in order is a word about the present and future.

Delaware, with its nine general hospitals containing 1,938 beds, four in Kent and Sussex and five in New Castle, has excellent general hospital facilities. The special facilities for mental diseases, tuberculosis, crippled children and convalescent care have 3,218 beds, making a total for the state of 5,146 beds. The institution for the mentally retarded at Stockley, with its new M. A. Tarumianz Hospital Center which opened in June last, and the unusual facilities in our Governor Bacon Health Center for emotional problems in childhood, cerebral palsy, alcoholism, epilepsy and many other conditions, are most important segments of our in-patient services. Then, too, the Old Age Home at Smyrna, with its hospital facilities, is excellent. These institutions well provide for the hospital needs of our population and the practices of our physicians. In addition to the institutions, the state has well-organized crippled children's clinics, maternal and child health (MCH) centers and many other special clinics, such as those for cancer, tuberculosis, heart, etc. In the Eugene duPont Memorial Convalescent Hospital we have a facility, the like of which very few states can boast. Its in-patient rehabilitation service and the Curative Workshop for outpatient service give Delaware excellent facilities in the field of physical medicine and rehabilitation. The latest addition to the state's facilities for rehabilitation of the handicapped is our Sheltered Workshop, the Opportunity Center; it has now ninety trainees and workers representing all types of handicapping conditions. Of these institutions, facilities and services, we can be justly proud, but the medical profession and its State Medical Society have a challenging responsibility—a responsibility to improve and advance the quality of service given to those in need of medical care in and out of these institutions, and responsibility is defined as "an obligation, trust and duty"—a very serious charge.

For a doctor to be able to improve and advance the quality of service, he must accept the principle of continuing education. It is an ongoing and never ending process. He must look upon himself as a perpetual student. If he does not, he may easily slip into that "muddy rut of self-sufficiency" as mentioned by Dr. Dawson. It is the duty of the Medical Society to make this continuing education possible to the utmost of its abilities. This is being done through seminars on selected subjects, Medical Society meetings, and beginning this fall, a two-way radio teaching program of 30 hours between the Continuing Education Division of the Pennsylvania Hospital in Philadelphia and nine stations in Delaware,


HEALDS' HYGEIAN HOME,
WILMINGTON, DELAWARE.
"SWEDISH MOVEMENTS,"
MASSAGE.
"RELATIONS OF THE SEXES,"
Robert C. Pyle,
Coudersport,
Pa.

The unusual features of Heald's Hygeian Home are advertised on this card, postmarked March 10, 1884, Wilmington, Delaware.

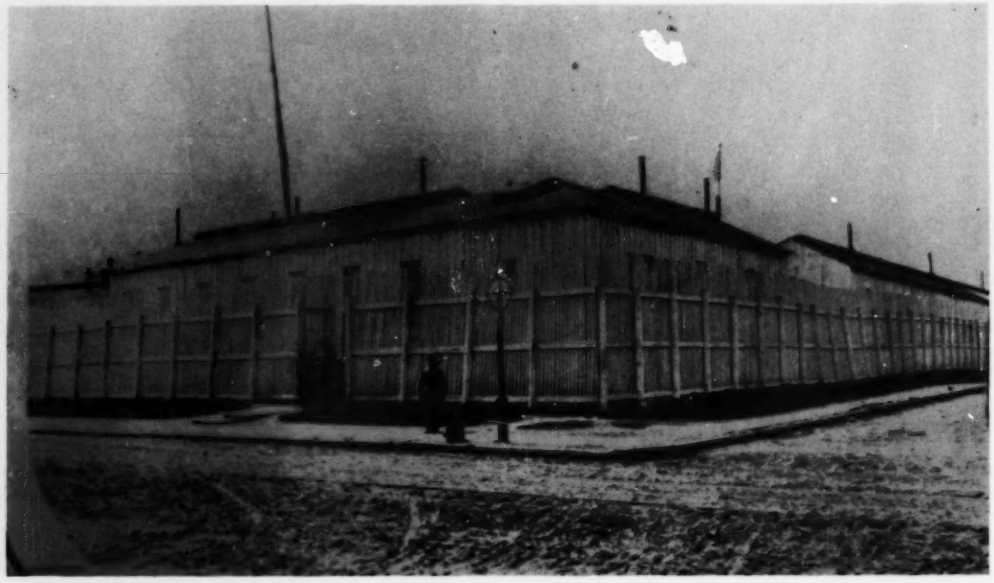
seven of which are located in our hospitals. This latter is an experiment which it is hoped the doctors will like, get something out of, and want to continue.

Too much emphasis cannot be placed upon the part the general practitioner plays in medicine in a community. He is the first line of medical practice, the first one to establish the doctor--patient relationship, and the soul of good practice. What he does and says is what the general public most often judge the whole medical profession by. In Delaware we have a very strong and active Academy of General Practice, which since its organization has enthusiastically supported graduate education programs.

Each physician, general practitioner, and specialist, alike, must adopt high standards of medical care and conscientiously strive to live up to these in his practice. A doctor should always dedicate his efforts to the achievement of excellence in maintaining these standards of care and never compromise with this principle, for if a compromise is made, mediocrity in practice results.

It has been said that the four essential parts of a physician are tolerance for his fellow man, humility in what he is doing, sincerity to all, and honesty, and to these four should be added common sense, without which a good doctor cannot function. A physician's honesty should apply to constant evaluation of his practices as well as his capabilities and skills in medicine, always aware of his limitations. For a doctor to attempt certain surgical procedures without being properly trained, or to treat patients with new and uncertain drugs before these drugs are proven to be safe and better than the old, is not rendering good medical care. Delaware is blessed in this day and age with doctors in every field of medicine. In two decades the membership of our Society has increased from 228 to 424, and among our new members are young and well-trained men from the best of medical centers, doctors who are qualified to do almost everything in the practice of medicine and surgery. The skills and capabilities of our new men should be slowly integrated into the practice of medicine in our communities to insure the best quality of practice of which we as a medical profession in Delaware are capable.

This frequent and conscientious evaluation of our individual practices should be extended to apply to the programs and activities of our Medical Societies. Your State Society, guided by its Council, has been doing what it thinks it should do. It has by no means done all which could be done, but measures up well to what a society can do in a small state. The Society has always enjoyed good relationships with the American Medical Association and the AMA is constantly called upon for advice and counsel. The many reports which come



The Tilton Hospital, with its stockade appearance, was the first general hospital in Delaware, built in 1863 at 10th and West Streets for the Sick and Wounded Soldiers, named for Dr. James Tilton.

in from the AMA office are carefully studied by our executive secretary, discussed with the president, and referred to the appropriate committee for action and recommendation.

During the past year there have been a few very active committees. Particularly pleasing is the activity of the Committee on the Aged. The focus of this meeting today, as you can see from your programs, is on our senior citizens. This afternoon we have five, extremely well-qualified, out-of-state speakers—two AMA presidents who have been particularly interested in the subject—to bring you the latest on the geriatric problems of practice. Our aging population and how to keep it well and happy presents the greatest challenge medicine has today and will be even more so in the years to come. Our Society must plan and plan adequately to meet this challenge.

Your speaker is particularly interested in what is going on in rehabilitation. The Eugene duPont Hospital services are our latest and best. Each one of us should be proud of what Dr. Arthur Heather has been quietly and efficiently doing for the severely handicapped of our state in this institution and see for himself his program. Our Curative Workshop, under the leadership of Miss Eleanor Bader, has developed into a really great institution for a physical restorative service in a community. It is nationally known and many from afar come to see what is going on. With the realization by Delaware physicians of what good rehabilitation can do for a patient, how many days lost from work and normal activity it can save, and how much sooner many patients can be made ambulatory and happier, it is hoped that these services may be better and more often used by all. Our hospitals have become crowded and many patients could be as well cared for in the home as in the hospital with the better use of the home care and rehabilitation services now existing.

One of the things your speaker wishes to bring to your attention is the one-year term of office of the president. One year is not enough for a president of a state society to show much in the way of accomplishment. It takes two months or more to become

oriented and to take hold of the office. By the time a good start is made on a worth while and productive program, the year is over. In the early days of our Society there were many presidents who had terms of two or more years; in fact, there were only eight presidents in the first fifty years. I would like very much to see the term of office of the president increased to, at least two years and preferably three. This principle has been accepted by our own Academy of Medicine and many special societies, and other organizations.

One of the best actions our Society has taken in recent years was the establishment in 1956 of the office of the executive secretary on a full-time basis. After this year of working so closely with Mr. Lawrence C. Morris, it is hard for me to realize how the Society functioned adequately before this office was created. The association I have had with our executive secretary has been most satisfactory and one of the most pleasant experiences of my term of office. Mr. Morris has always been a ready listener and a willing worker with vision and imagination. He has an unusually good grasp of the part a State Society should play in the practice of medicine and in its relationships with the AMA, and to Mr. Morris I wish to sincerely express my appreciation for his excellent services during my term as president.

So, I bring these rambling remarks to a close, first, with the wish that the few ideas I have given may stir up your thinking and imagination on matters pertaining to Delaware's practice of medicine and, secondly, with the hope that our leaders may always have the right vision, that vision so necessary to put our responsibilities into proper focus, essential for progress and better medical care.

CLINICAL CENTER STUDIES

The National Institutes of Health, Bethesda, Maryland announce 4 clinical center studies. The cooperation of all interested physicians in referring patients for these investigations is being solicited.

Thyroid Cancer

For the study of carcinoma of the thyroid gland, the Radiation Branch requires patients in whom diagnosis is established but who are not in the terminal phase of the disease.

Chondrosarcoma

The primary purpose of this study is to determine the possible affects of large doses of radio-active Sulphur—35 on patients with inoperable but accessible (for biopsy) chondrosarcoma. Physicians interested in these two studies may contact: Charles G. Zubrod, M.D., National Cancer Institute. (Telephone OL 6-4000, Ext. 4346.)

Childhood Solid Tumors

The tumor types of particular interest for this study include Wilms' tumors, neuroblastomas, rhabdomyosarcoma, sarcoma botryoides and the lymphomas. Contact: Dr. Clyde O. Brindley, National Cancer Institute (OL 6-4000, Ext. 4252).

Hypertension

The National Heart Institute is interested in patients having moderate to severe hypertension which is either primary or renal in origin. Contact: Dr. Louis Gillespie, Jr., National Heart Institute (OL 6-4000, Ext. 3175).

REMARKS OF JOHN A. PERKINS, Ph.D.*

AT THE DEDICATION OF THE DELAWARE ACADEMY OF MEDICINE

It is always a significant and happy occasion when a building project is completed and dedicated or rededicated to a useful purpose. This is such an occasion.

The completion of the addition to the Delaware Academy of Medicine building is particularly significant. The building commemorates the past. In the present it provides a more useful home for the Academy. Its improved accommodations may inspire its users to future activities to meet professional and community needs, especially medical ones.

This structure, as most everyone present is aware, was originally built in 1816 as the Sixth and Market Street home of the old Delaware Bank. Its handsome "federal period" appearance aroused to action those civic minded persons who combined a love of beauty and a rich sense of history when in 1931 it seemed that the structure must be razed. They held it should be relocated on this site.

Simultaneously, local medical leaders were equally determined. They were inspired, however, by the demands of science and technological advancement. In spite of the onset of the Great Depression they sought to meet several community needs: Twenty-five years ago there was no medical library in the State of Delaware. Secondly there was no home site for the various medical societies and societies allied to medicine. Thirdly, residency programs had not yet developed in the hospitals of the community; finally, there was a particular, but indeed an ever-present need, to stimulate and direct continuing post-graduate medical education. Courses, lectures, symposia and panel discussions were necessary for would-be up-to-date practitioners. Citizens, it was believed, could also benefit from lectures on broad public and personal health topics. In response to these identified needs, the Delaware Academy of Medicine was brought into being. At its founding there were only sixteen members. Today, there are three hundred and twenty members comprising about eighty percent of the Wilmington physicians. Not to be confused with local and state medical societies, this type of voluntary association and its activities are *usually* found only in large cities such as Philadelphia, New York, and Toronto.

The extent to which the Academy has successfully met the needs which first brought it into being can only be suggested. From nothing, the library has grown to 10,000 volumes. It now receives nearly 200 medical periodicals annually. Naturally, greatest use of the library is by the health

*President, University of Delaware.

related professions. It also serves lawyers, industries, University students and faculty and neighboring research agencies. Even secondary school youth preparing for Science Fair participation find the library of value. The enlarged building gives the library facilities for housing twice as many volumes and a larger reading room. Well over a hundred meetings are now held annually in the Academy building. Inevitably a larger number will be held in this beautiful, enlarged auditorium. The Academy sponsors four public health forums annually which have brought before the Delaware public such authorities as Drs. William Menninger and Paul Dudley White. When the eminent English physician, Dr. John B. Scadding, was in this country recently, the Academy alertly invited him to address one of these forums. I recently read Dr. Lewis B. Flinn's paper on the Academy which he wrote six years ago. Two comments of his, related to both educational and library activities, stick in my mind and I will enlarge upon them in a moment. First, he pointed out that the development of residency programs within certain departments of some of the hospitals had necessarily brought about educational programs in them. As a result, specialty groups after World War II do not hold sectional meetings at the Academy *as they once did*. Secondly, he recognized that busy practioners have little leisure time to go to the Academy reading rooms. Dr. Flinn envisioned and commended establishment of an extern service under which books—upon telephone request—would be delivered to the physician's home, office or hospital, and an inter-library loan service which universities and their scholars have found of great aid in extending the limited resources of any single library. It is most gratifying that these important extensions of the library have developed.

To mention these developments from years past suggests to the layman thoughts about the future.

Seldom does any organization achieve *all* that it might. According to the cynical Englishman, T. Northcote Parkinson, occupation of new and beautiful facilities in-and-of themselves may mark the *decline* rather than the *increase* of creative accomplishment. Parkinson's Laws are intriguing generalizations. But they are only worthy admonitions, not tested truths. With a library twice as large, will the doctors read twice as much? Will this enlarged auditorium and the other facilities for meetings attract proportionately larger audiences and with greater frequency? In view of the rapid growth of knowledge in the biological sciences of which medicine is a practical manifestation, the answers to both questions *should be* an unequivocal "yes."

In the future the library should be, even more than it is today, the heart center of the Academy's activity. Its importance to responsible and conscientious practitioners in an age of exploding scientific discovery cannot be over-emphasized. At the turn of the century when there was so much less for doctors to know than now, Sir William Osler admonished: *"For the . . . practitioner, a well-used library is one of the few corrections of the premature senility which is so apt to overtake him . . . It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it."* As an educator, it is with great forbearance that I do not launch into the subject of how to read more rapidly and more widely. It is skill, however, to be acquired for the improvement of your art quite as certainly as doing ward rounds." Again, Osler's words make the point: *"To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all."*

Now as to the future of the Academy as a meeting place. We must, as laymen and professionals alike, find satisfaction in the extent to which our local hospitals have become teaching institutions. Regret must, however, still be expressed that they are not *all* fitted out in *all* departments with a complete complement of interns and residents. This is not possible nor is it likely to be if the board men, or recognized specialists, in each hospital are concerned for only their

own service in the hospital where most of their work is done. Today's members of this Academy must be as concerned with the improvement and strengthening of all medicine in this geographic area as were its founders. A pioneering but necessary step for today would be to bring about an integration of the specialists among all the hospitals. The result would be a strengthening of the total hospital resources by reason of a community-wide, inter-hospital teaching program in every medical specialty. Then this building might once again be the home site for sectional meetings, a true educational center of the total profession. The greatest significance would be the end result. We would not then have hospitals only partially staffed and, in some respects, limping along rather than running strong as teaching institutions. Instead, we would have complete community of teaching and well-taught physicians practicing in completely staffed hospitals—all teaching ones. Of course, better medical care for patients would follow. Most of today's good realities are but yesterday's dreams. The poet O'Shaugnessy wrote that dreamers

". . . are the movers and shakers of the world."

To suggest one idea that would call for a *little* professional cooperation and coordination prompts another that calls for a *lot* of the same spirit. I am embolden to my second suggestion for the future by reason of the Academy's record of enlightening the public about specific diseases and public health in general. A movement has already been initiated by the leadership in some cities, to shift planning in the hospital and other health services from a single institution or activity approach to a *community-centered* and total *health needs approach.* Historically the earlier way was necessary to the adequate development of individual programs and facilities. Comprehensive and long-range planning is not a Russian or foreign idea, it was literally invented by large and complex industries in the United States. It should be emulated in our public affairs.

Population in Delaware is expanding at both ends of the age spectrum. The remainder of the people now in their working years are of necessity burdensomely levied upon to care for more youth and more geriatric cases. Rehabilitation opportunities have grown especially through advances in physical medicine and mental therapy. There is so much to be done. There is so little in manpower and resources to do it all, in even a comparatively rich community. Only if no effort is duplicated and no money wasted, can hospital beds, outpatient centers, diagnostic and treatment centers, chronic disease and nursing and convalescent homes, and rehabilitation centers be established in adequate numbers. To staff these health facilities, more also needs to be know about the adequacy of supply and training of technical personnel in the health field.

From a strictly public health standpoint, burgeoning suburbs such as we have in New Castle County call for development of master plans and keeping them up to date relative to water supply and sewage disposal facilities. Our plans will need coordination with the larger metropolitan area, aptly called Pen-Jer-Del. In most urban jurisdictions with growing populations, archaic ordinances and statutes exist with respect to food, milk and sanitary inspection, not to mention disease reporting. Health research and its financing perhaps is a problem too. It is receiving community-wide attention only in larger cities.

It is my hope that the Delaware Academy of Medicine and the Academicians will show their gratitude to the donors of this enlarged and refurbished structure by deeds as well as words. Speaking to our medical friends here, let me say you can do so by making selfless and larger contribution to medical and health progress in Delaware. Follow literally, gentlemen, the stated purposes of your Academy Charter: *". . to foster among its members interest in medical, scientific, literary and educational conditions and to render service without recompense toward these ends. . ."*

President's Page

The act of incorporation of the Medical Society of Delaware dates from 1789, and is one of the oldest of its kind in the nation. Particularly interesting are the reasons given for the organization of the state's physicians—that medicine "should be conducted on some permanent establishment of regularity and permanent utility."

"Permanent utility" is a broad phrase, offering a lot of latitude. To mean anything, it has to mean that the Society should change with its time, shifting program to meet responsibility, emphasis to meet need, but *not* principle to meet expediency.

The Journal AMA noted in November that this might be called one of those centuries when everything goes wrong. It's a wonderful century, of course, but it's a highly accelerated one, and nothing changes faster than the doctor's needs and responsibilities.

Trying to meet them, the Society has executed a quick shift from "scientific and professional organization" to "business league" for tax purposes, while simultaneously developing an excellent scientific and professional program, resources considered. Mobility of resources has become important, and the recently-adopted commission structure will, many of us think, allow us to utilize our assets better than has been done in the past.

The permanence of our utility as a society rests on three bases; professional education and influence, public education and influence, and communication. While I will write more on this from month to month, I want now to express the hope that we, as a profession and as a professional society, may competently and intelligently use these fundamentals, both as means and ends, to accomplish our goals and justify the simplicity with which the General Assembly of 1789 permitted us to chart our own future. I suggest that only through active participation can we expect to achieve this.

James E. Manuel

President, Medical Society of Delaware

In Brief

Project Hope

The field of international health will have a concrete base when the moth-balled Navy hospital ship *Consolation* is launched as a floating medical center and sent on a year's visit to Southeast Asia. This is the plan inaugurated by the People-to-People Health Foundation and directed toward bringing the latest medical skill developed by the American medical profession to the people of the Far East. The ship will be staffed with a permanent personnel of 15 physicians, 2 dentists, 20 graduate nurses, 20 technicians, and with rotating volunteer units of generalists and specialists who will be flown to the ship for tours of four months. The AMA and the ADA have endorsed the plan publicly and pledged generous support. The added support of the American medical profession as well as that of corporations, foundations and individuals will be needed.

Disturbing Trends

According to the Association of American Medical Colleges, the total number of medical school applicants seems to be decreasing in the face of rising enrollments and graduations. The number entering medical schools with an average grade of "A" is also on the decrease. While the actual number of doctoral graduates in all categories has increased since 1935, the trend is downward in the percentage distribution of doctoral graduates in the biological sciences from 1935 to 1956. A changing pattern of medical school income is also noted. Funds derived from state, university and other sources for medical school expenditures has been building up and the proportion of expenditures for separately budgeted research increased approximately 2½ times during the period 1940-1957.

Memorial

The George W. Merck Memorial has been established in the form of a loan fund to encourage deserving interns and residents seeking the best possible postgraduate training. The loan fund will supplement the stipends available at teaching hospitals. Graduates of a participating medical school may receive an award wherever they are in training. Deserving graduates of other medical schools may also receive an award who are in training in hospitals associated with the participating plan.

Monograph Prizes

Three $1,000 prizes to be awarded — one each in the fields of the humanities, social sciences and the physical and biological sciences — to authors of unpublished monographs, has been announced by the American Academy of Arts and Sciences, 280 Newton St., Brookline, Boston 46, Mass. Write there for particulars. A monograph is defined as a "Scholarly contribution to knowledge, too long for an article in a learned journal and too specialized for a general book." The final date for receipt of manuscripts is October 1st, 1960.

Industrial Medicine To the Fore

Graduate fellowships in industrial medicine are now being offered by the University of Cincinnati's Institute of Industrial Health. Graduates of approved medical schools who have completed at least one year of internship are qualified applicants. The three-year program leading to the degree of Doctor of Industrial Medicine satisfies the requirements for certification in Occupational Medicine by the American Board of Preventive Medicine. Two other programs of study offered are: a one-year course for the degree of Master of Science and a three-year academic program, leading to the degree of Doctor of Science. Fellowship stipends are available to eligible candidates in all programs. Write to: Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

See-Saw

While the rate of admission to general hospitals in this country has increased by almost 80% in the last 20 years, the hospital patient of today usually goes home much sooner. This decline in the average length of stay per patient is largely the result of new medical knowledge, early ambulation following surgery, new medical and surgical procedures, and new pharmaceutical products, says the Health Information Foundation. The HIF also reports that children need hospital care less often than they did 20 years ago, largely because admission rates for two common operations, tonsillectomies and appendectomies have declined by about half.

A "First"

Sound advice on how to build an estate for the future of a crippled child has been published by the National Society for Crippled Children and Adults, as a friendly source of guidance for parents of afflicted children, who know they must take unusual measures to protect their children's future. Copies of "Building an Estate for a Crippled Child" are available at 25¢ a copy from all the state chapters.

New Figures

The Society of Actuaries — Institute of Life Insurance — is releasing its 1959 Build and Blood Pressure Study in November. It will make obsolete the table of figures now shown on weighing machines and used by physicians throughout the country. The new weight tables are based on a study covering 20 years of statistical investigation regarding body build and blood pressure. Significant finding shows that women weigh distinctly less than a generation ago, while men tend to be heavier than their fathers — and that weight reduction pays. Those who were overwight when insured, showed a return to normal mortality after reducing in weigeht.

Complexity Pays

An article in GP points out that the female body appears to be more complex and requires more repair work than the male body, especially in its glandular equipment. It adds, that by the time human life expectancy hits 100 years, there will be five women for every two men.

Editorials

TAKE TIME TO EXPLAIN:

Dr. A. Carlton Ernstene, Chairman of the Division of Medicine of the Cleveland Clinic, once wrote in *Circulation* on the subject of explanation in cardiologic practice. He began by mentioning the great advances in our knowledge of heart disease that have occurred in the past fifty years. He emphasized that the cooperation of a patient — in carrying out proper treatment —could be more easily obtained if that patient were given a clear explanation of the problem and the solution that was to be attempted.

Attention to details by the patient may spell the difference between success and failure in many therapeutic procedures. Drastic changes in habits frequently are necessary in patients with angina; an explanation of the reason for such change is most important. Acute myocardial infarction—a disease that incapacitates a man at the height of his active life—can be tolerated better if the patient knows the reason behind the severe restrictions imposed and has a rough idea of their probable duration. The patient with congestive heart failure will be more cooperative in his sodium restriction if he knows why it is being restricted.

The patient with emotional problems, tension, insecurity, and anxiety symptoms focused upon the cardiovascular system will rationalize his symptoms far better if the physician's reassurance that he has no heart disease is accompanied with an explanation of the cause of the symptoms.

Premature beats and dyspnea — two alarming conditions — can be well tolerated if explained.

The public has been made aware of the great advances in scientific medicine and takes much for granted. They do desire, however, personal attention from their physician. "There is a desire in each of us to be recognized as an individual, and because of this no one enjoys being looked upon solely as an example of a particular disease or syndrome." Some patients fail to ask questions because of timidity or fear of the answer. The experienced clinician becomes aware of what the patient would like to know; to omit an explanation because of thoughtlessness or pressure of practice constitutes neglect of an obligation to the patient and loss of a most important therapeutic tool.

Doctor Ernstene's editorial contains much wisdom; it applies not only to the practice of cardiology but to the practice of medicine as a whole. So much misunderstanding could be avoided and so many benefits would ensue if we would *take time to explain the problem to the patient.*

AULD LANG SYNE —

1959 was a year of change for The Journal; a change for the better. Many of our members have noted and commented upon the greatly improved format. This new look is due to one person — our assistant editor.

Perhaps at the year's end we should think about any desired changes in content. We have repeatedly stated that this is *your journal* and we want the material to be that which is most helpful to the greatest number of our members. Let us have your criticism — we'll do our best to oblige.

Likewise, we should think about the annual meeting for 1960. Drop President Marvil a line and tell him the type of program that would interest you — it's *your meeting.*

Best wishes for 1960!

Books

The Library of the Delaware Academy of Medicine
Accessions from September, 1959

ANATOMY

Netter, Frank H.: Digestive System, Vol 3, Part 1, 1959. Ciba Collection of Medical Illustrations

BACTERIOLOGY

Ciba Foundation: Steric Course of Microbiological Reactions, 1959. Little Brown, Co.

CARDIOVASCULAR SYSTEM

Foley, William T. and *Wright, Irving S.*: Color Atlas and Management of Vascular Disease, 1959. Appleton-Century-Crofts, Inc.

Rosenbaum, Francis F. and *Belknap, Elston L.*: Work and the Heart, 1959. Haeber

Spodick, David H.: Acute Pericarditis, 1959. Grane and Stratton

DENTISTRY

Moorees, Coenraad, F. A.: The Dentition of the Growing Child, 1959. Harvard University Press

Moyers, R. E.: Handbook of Orthodontics, 1958. Yearbook

Schwaryrack, L. H. and *Schwaryrack, S. P.*: Effective Dental Assisting, 2nd edition, 1959. Brown

ENDOCRINOLOGY

Sindoni, Anthony M., Jr.: The Diabetic's Handbook, 2nd edition, 1959. Ronald Press Company

MEDICINE

Ciba Foundation: Pain and Itch, 1959. Little, Brown Co.

Dreisbach, Robert H.: Handbook of Poisoning, Diagnosis and Treatment, 2nd edition, 1959. Lange

MISCELLANEOUS

American Medical Association: Digest of Official Actions, 1846-1958. 1st edition, Vol. 1

Cooper, Robert U.: Investments for Professional People, 2nd edition, 1959. Macmillan Company

Cross, Louise M.: Preparation of Medical Literature, 1959. Lippincott

NEOPLASTIC DISEASES

Hamburger, F.: The Physiopathology of Cancer, 2nd edition, 1959. Haeber

NEUROLOGY

Pack, G. T. and *Ariel, I. M.*, eds.: Tumors of the Nervous System, 2nd edition, 1959. Haeber

OPHTHAMOLOGY

Clark, William B.: Symposium on Glaucoma, 1959. Mosby

Lewin, Philip: Foot and Ankle, 4th edition, 1959. Lea and Febiger

PEDIATRICS

Debaban, Annatole: Neurology of Infancy, 1959. Williams-Wilkins Co.

PHARMACOLOGY

Foulger, John H.: Chemicals, Drugs, and Health, 1959. Thomas

Searle Research Laboratories: Proceedings of a Symposium on Enovid, 1958. Searle

RADIOLOGY

Merrill, Vinita: Atlas of Roentgenographic Positions, 2nd edition, 1959. Mosby

SURGERY

Kazanjian, Varaztad H. and *Converse, John Marquis*: The Surgical Treatment of Facial Injuries, 1959, 2nd edition. Williams and Wilkins

Moore, Francis D.: Metabolic Care of the Surgical Patient, 1959. Saunders

Ochsner, Alton and DeBakey, Michael E., eds.: Christopher's Minor Surgery, 8th edition, 1959. Saunders

Peer, Lyndon A., ed.: Transplantation of Tissues, 1959. Vol. II. Williams and Wilkins

UROGENITAL SYSTEM

Colby, Fletcher H.: Pyelonephritis, 1959. Williams and Wilkins

TWO-WAY RADIO CONFERENCES FOR THE COMING MONTH

Sponsorship: *Medical Society of Delaware, Pennsylvania Hospital, Smith Kline & French Laboratories.*

Date	*Topic and Faculty*
Dec. 22	"New Drugs in Therapy of Hypertension" Garfield G. Duncan, M.D.
Dec. 29	"Radio-Isotopes in Thyroid Dysfunction." George R. Fisher, III, M.D.
Jan. 5	"Modern Therapy of Peptic Ulcer." Alexander Rush, M.D., Gastroenterologist to Pennsylvania Hospital.
Jan. 12	"Hormone Therapy in Carcinoma of the Breast." Charles H. Cretzmeyer, Jr., M.D., Assistant Surgeon to Pennsylvania Hospital.
Jan. 19	"Current Status of the Chemotherapy of Malignancy." Edward H. McGehee, M.D., Hematologist to Pennsylvania Hospital and Physician to the Hospital.

REPORT OF PROCEEDINGS

THE HOUSE OF DELEGATES

MEDICAL SOCIETY OF DELAWARE

The House of Delegates meeting of the Medical Society of Delaware was called to order at 3 o'clock p.m., Sunday, October 11, 1959, President Alfred R. Shands, Jr., M.D., presiding.

PRESIDENT SHANDS: The meeting will come to order.

We have a great deal of business this afternoon and immediately following there is a supper served downstairs for the delegates and all those in attendance.

The first order of business is the roll call and the Secretary will proceed with that.

Secretary Cannon then took the roll call.

SECRETARY CANNON: There is a quorum present.

PRESIDENT SHANDS: The next order of business is the minutes of the last session. Mr. Secretary.

SECRETARY CANNON: The minutes were published in the State Journal, sir, and I would like a motion to have them approved as printed.

A motion was made, seconded and carried to approve the minutes of the last session.

PRESIDENT SHANDS: The next item is the report of the officers, the first being the President's report. He will give the so-called President's address at the first session on Thursday. At this time I wish to say that I think we have had a very successful year on the whole. There have not been too many controversial subjects. You will hear reports of the other officers and reports of the committee chairmen and the other business which will really constitute what a President's report should have.

The next report is that of the Secretary.

REPORT OF SECRETARY

The office of the Secretary has been conducted on a current basis during the past year. Minutes of the Council meetings have been kept.

Respectfully submitted,
NORMAN L. CANNON, M.D.

This report was accepted.

The next is the Treasurer's report.

DR. CHARLES LEVY: The audit report of the Medical Society of Delaware has been prepared by the accounting firm of Hagerty & Hagerty, Certified Public Accountants in the City of Wilmington.

Our financial condition is reported excellent. The present statement is for the year July 31, 1958, to July 31, 1959. The Society, however, must return to our previous fiscal year of accounting, that is, January 1 to December 31, and this follows the directive of the Internal Revenue Service.

I do not have a sufficient number of these reports from Hagerty & Hagerty to hand out to everyone here. However, those on the financial and budgetary committees will receive copies of this report.

REPORT OF THE TREASURER

October 8, 1959

Member of Council
Medical Society of Delaware
Wilmington, Delaware

Gentlemen:

We have examined the financial records of the Treasurer of the Medical Society of Delaware and the Delaware State Medical Journal for the year ended July 31, 1959, the results of which are included in this report, consisting of the commentary and the following statements:

Title:	Exhibit and/or Schedule
Balance sheet at July 31, 1959	A
Comparative statement of cash receipts and disbursements for the years ended July 31, 1959 and July 31, 1958:	
General fund	B
Delaware State Medical Journal	C
Budgetary statement of revenue and expenditures for the year ended July 31, 1959:	
General fund	D
Statement of securities owned at July 31, 1959 and income therefrom during the year then ended:	
General fund	A-1
Reconciliation of dues and A.M.A. assessments for the year ended July 31, 1959:	
General fund	B-1

Scope of Examination

Testings were made of income and expense factors in both the Treasurer's records and those of the Delaware State Medical Journal to the extent we deemed appropriate in the circumstances. Cash received was traced to deposits in bank and expenditures were verified by reference to cancelled checks and/or vendors' invoices. Cash in banks as of July 31, 1959 was confirmed direct to us by the various depositories and reconciliations were made with the book balances therefor at that date. Securities owned at July 31, 1959 were examined by us at the Bank of Delaware on October 6, 1959, in the presence of Charles Levy, M.D., and income earned thereon, during the period under review, was verified by recomputations or reference to accredited financial publications. Other verifications deemed necessary are commented upon in the ensuing paragraphs of this report.

Commentary

A statement of financial condition at July 31, 1959 is presented in exhibit A; while comparative statements of cash receipts and disbursements, in both funds, for the years ended July 31, 1959 and July 31, 1958 are included herein as exhibits B and C, respectively.

The society maintains three separate savings accounts, the transactions of which are not included in the operating statements of this report, but the changes therein during the year under review are detailed in the following tabulation:

Balances,	General Fund Wilmington Savings Fund Society	State Medical Journal Wilmington Savings Fund Society	Journal Wilmington Trust Company
August 1, 1958	$4,961.24	$3,744.37	$1,765.54
Receipts			
Interest earned	173.64	131.04	17.65
	5,134.88	3,875.41	1,783.19
Disbursements			
None			
Balances, July 31, 1959	$5,134.88	$3,875.41	$1,783.19

At the Wilmington Savings Fund Society, interest is currently credited to accounts as of December 31 of each year at the rate of 3½% per annum and the balances in the foregoing tabulation include interest through December 31, 1958. The rate of interest on savings accounts at the Wilmington Trust Company is 2% per annum but, effective in 1959, it will be credited to accounts only once each year at December 31 rather than semi-annually, so that the credit indicated in the foregoing tabulation is only for the six months ended December 31, 1958.

Detailed explanations were not available with respect to deposits in bank under dates of August 15, 1958, August 20, 1958 and October 8, 1958 and, in preparing the operating statements included in this report, we classified the source of these deposits to the best of our ability from other available data.

At its meeting on September 28, 1958, the House of Delegates authorized a contribution of $10,000.00 to the Academy of Medicine but, as of July 31, 1959, only $2,000.00 had been contributed.

Conclusion

In our opinion, the accompanying balance sheet and related statements of cash receipts and disbursements present fairly the financial position of the Medical Society of Delaware at July 31, 1959 and the results of the operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with the preceding year.

We wish to express our appreciation for the courtesies extended to us during the course of this examination.

Very truly yours,
Haggerty & Haggerty
Certified Public Accountants

Exhibit A

MEDICAL SOCIETY OF DELAWARE

Balance Sheet at July 31, 1959

Assets

General Fund:		
Cash in bank:		
Regular account—exhibit B	$10,249.55	
Savings account	5,134.88	
		$15,384.43
Investment—schedule A-1:		
Stocks	12,949.08	
Government bonds	13,085.00	
		26,034.08
Due from State Medical Journal		300.46
		41,718.97
Delaware State Medical Journal:		
Cash in bank:		
Operating account—exhibit C	8,562.70	
Savings account	5,658.60	
	14,221.30	
Investments—Government bonds	3,502.38	
		17,723.68
		$59,442.65

Liabilities and Fund Balances

General Fund:		
Liabilities:		
Employes' withholdings and accrued payroll taxes	$ 180.05	
Reserve:		
Defense fund	1,000.00	
Fund balance	40,538.92	
		$41,718.97
Delaware State Medical Journal:		
Liabilities:		
Due to General fund	300.46	
Fund balance	17,423.22	
		17,723.68
		$59,442.65

Schedule A-1

GENERAL FUND

Statement of Securities Owned at July 31, 1959
And Income Therefrom During the Year Then Ended

Face Value and/or Shares		Book Value 8-1-58	Purchases	Sales and Redemption	Gain	Book Value 7-31-59	Income Received Exhibit B
	BONDS						
$7,000	U.S. Savings bonds, series J, dated October 1953, due October 1965	$ 5,040.00	$	$	$	$ 5,040.00	$ .....
8,000	U.S. Treasury notes, 4's, series B-1962, due August 15, 1962	.....	8,045.00	.....	.....	8,045.00	(39.78) C
		5,040.00	8,045.00	.....	.....	13,085.00	(39.78)
	STOCKS						
99 shs	Bank of Delaware, capital, par $10.00 ..	1,725.00A	748.00	$ 26.50	$ 26.50	2,473.00	148.30
40 shs	Continental American Life Insurance Co., par $10.00	1,130.50	.....	.....	.....	1,130.50	64.00
40 shs	E. I. duPont de Nemours & Co., $4.50 pfd., no par	4,741.03	.....	.....	.....	4,741.03	180.00
70 shs	Farmers Bank of the State of Delaware, capital, par $5.00	2,800.00B	.....	.....	.....	2,800.00	280.00
15 shs	Hercules Powder Co., 5% pfd., par $100.00	1,804.55	.....	.....	.....	1,804.55	75.00
		12,201.08	748.00	26.50	26.50	12,949.08	747.30
		$17,241.08	$8,793.00	$ 26.50	$ 26.50	$26,034.08	$ 707.52

(A) Received 49½ additional shares in a 2½ for 1 stock split, sold fractional share March 23, 1959. Purchased 17 shares June 23, 1959.

(B) Received 63 additionall shares in a 10 for 1 stock split.

(C) Accrued interest — date of purchase April 1, 1959.

Schedule B-1

GENERAL FUND

For the Year Ended July 31, 1959
Reconciliation of Dues and A.M.A. Assessments

	TOTAL Members	TOTAL Amount	NEW CASTLE Members	NEW CASTLE Amount	SUSSEX Members	SUSSEX Amount	KENT Members	KENT Amount
STATE SOCIETY DUES:								
Dues received	392	$18,353.50	311	$14,617.00	48	$2,256.00	33	$1,480.50A
SUBSCRIPTIONS—								
STATE MEDICAL JOURNAL:								
Subscriptions received	392	$ 1,171.50	311	$ 933.00	48	$ 144.00	33	$ 94.50
Remitted to								
State Medical Journal	399	1,192.50	311	933.00	55	165.00	33	94.50
Difference (B)	(7)	$ (21.00)	.....	$	(7)	$ (21.00)	....	$ .....
AMERICAN MEDICAL ASSOCIATION:								
Assessments freceived	388	$ 9,662.50	309	$ 7,725.00	46	$1,150.00	33	$ 787.50
Remitted to A.M.A.	390	9,712.50	309	7,725.00	48	1,200.00	33	787.50
Difference (B)	(2)	$ (50.00)	.....	$	(2)	$ (50.00)	....	$ .....

(A) 3 members — Kent Society — paid only ½ year.

(B) Differences represent assessments of prior year not transferred until current year.

In summary then, the Society realized $23,710.08 income for the year. Total expenditures were $24,001.38, giving $291.30 as the net figure over-expended for the year.

A motion was made and seconded to accept the Treasurer's report.

PRESIDENT SHANDS: Next is the report of the Executive Secretary, Mr. Morris.

REPORT OF THE EXECUTIVE SECRETARY

A great deal of material is contained in the reports of the various committees, and I believe that you will find the record of the Society's accomplishments and failures within these reports. While it would be repetitious and would serve no useful purpose for me to go into detail about the efforts and special problems of each group, I should perhaps point out that no committee report can present completely the efforts and hours devoted to the projects it describes. Most of these projects have involved staff work to a greater or less degree, and I would prefer to review the highlights of the year's activitiese and perhaps present dimensions of the Society's efforts that do not appear in the reports themselves.

MEMBERSHIP

The executive secretary reports that the membership of the Society stands at 422, distributed among the counties as follows:

Kent County Medical Society — 32
New Castle County Medical Society —332
Sussex County Medical Society — 58

NEW OFFICES

A most important event this year has been the moving of the headquarters office to the Delaware Academy of Medicine. This has had a very good affect upon the accessibility of the headquarters office to the membership. Housed as it now is in the same building with the offices of the New Castle County Medical Society and of the Delaware Academy of Medicine, and with adequate parking space, the office is visited by an increasing number of physicians, whose presence has been most welcome and whose suggestions have been most helpful to your staff in evaluating the desires of Delaware's doctors.

ANNUAL MEETING

Another major change will be evident in the format of this year's annual meeting. For the first time in many years there will be no technical exhibits at the annual scientific session. This move has been made at the direction of the Council, and was predicated upon two factors. First, the amount of time spent by the average physician-member at the technical exhibits has raised considerable doubt that the individual doctor wants them continued. Second, the increased cost of erecting special partitions and wiring for technical exhibits substantially decreases the net return from the exhibits, and, when considered with the amount of staff time required to arrange a proper technical exhibit, it is questionable whether the number and the price per unit of the technical exhibits have actually resulted in a profit to the Society.

It is, of course, one of the major responsibilities of a professional society to offer its members opportunities for continuation education. This year's radio conferences, when combined with the annual meeting and the local seminars of the State Society's Committee on Education, will offer five times the number of hours of education that resulted from the traditional program, and should reach twice as many people. This is probably more realistic for the problems of this particular state. It is, however, experimental and, if the members wish, the meeting can be returned to the traditional basis.

JOURNAL

A third very important development has been the emergence of the Delaware State Medical Journal as a positive financial asset as well as a medium for intra-professional communication. The Journal has found itself able to assume a significant proportion of the operating expenses of the Society, including slightly more than 35% of the total payroll and 50% of the contribution to the Delaware Academy of Medicine, paid in lieu of rent.

With the change in printers anticipated last year, we have been able to return the Journal to its original publication schedule, and have been pleased at the quality of production of the Truitt Printing Company. The Journal continues, by exchange, to provide a major portion of the periodicals in the library of the Delaware Academy of Medicine.

Plans are being made to use the Journal to increase intra-society communication, and to offer more membership features. Among these have been the President's Page, now established as a monthly feature. In the near future, a current summary of Council minutes will be presented for the information of all members.

POLICY

Two major matters of policy deserve mention. One is the issue of closed panel plans, referred to the Society by the American Medical Association House of Delegates. The specific question involves the ethical and intra-professional status of these plans, but the broader and more important implication is the reaffirmation by the American Medical Association that policy must and should emanate from the county and state society level. The other is the Social Security poll conducted in May, resulting in an expression by the membership of a desire for physician-inclusion in the program. Again, the point is that major policy was referred to the membership, rather than to elected bodies.

POLIOMYELITIS

With the large increase in the number of cases of poliomyelitis evident throughout the country early this spring, President Shands appointed a Committee on Polio Immunization which reactivated the polio immunization campaign successfully implemented by the Medical Society, the State Board of Health, and the Delaware Chapters of the National Foundation in 1957 and 1958. While the results of this program are impossible to assess statistically, the fact that Delaware has been one of the very few states in the nation to experience a decrease in polio during 1959 can probably be attributed to the interest and active participation of the doctors.

LEGISLATION

The Society's problems with local and federal legislation have been thoroughly covered in the report of the Committee on Public Laws. The

Society owes a large debt to this committee, of which it is particularly true that relatively little of the actual activity shows in the report. If one lesson can be drawn from the Committee's experience this year, it is that personal participation by physicians to reinforce staff work is the only effective means of exerting a direct and positive influence upon the legislation in which the Society interests itself. The Committee on Public Laws is in the process of laying plans to increase this participation and you will be hearing of these efforts during the year to come.

On a national level, the Forand Bill and Forand-type legislation remains an active issue, contrary to some reports. The fact that both Delaware Senators are on the Senate Finance Committee, to which this bill will in all likelihood be referred if it passes the House, makes it particularly important for local doctors to keep themselves informed on this issue during the next nine months.

COMMITTEE ON AGING

While it is unfortunate that the problems of our aged population should be intimately connected with legislation, it is impossible to separate completely the two while Forand-type legislation remains active. One of our major handicaps in the past has been the lack of reliable information available to anyone on the actual situation of the aged. The Society's Committee on Aging has been working diligently this year to correct the deficiency, and while it cannot be said that the present status of the Committee's work is at all final, it is a direct and positive approach to one of our major medical problems, and should be considered by the Society as such.

GROUP INSURANCE

The Council this year reviewed the experience and rating of the Society's accident and health insurance program, and concluded that it has been well and fairly operated. Therefore, Bertholon-Rowland and Company was authorized to reopen the group for the participation of those members who desire the insurance.

STAFF

The Executive Secretary wishes to express his appreciation to Mrs. Winifred Donnelly and Mrs. Melita Phillips of the headquarters staff for their loyalty and devotion to the purposes of the Society. They have each contributed many uncompensated hours. The staff as a whole wishes to continue to improve its service to the Medical Society of Delaware, and its members are, without exception, engaging in various formal and informal courses to make this possible.

There are inevitably two questions which recur to the staff. They are "What are we doing wrong?" and "What are we not doing that we should be doing?" These are questions that can only be answered by the members themselves, and we hope sincerely that you will give us the benefit of your recommendations and criticisms.

In conclusion, I want to express my own appreciation to the officers and members of each county medical society for their coursesy and hospitality when I have visited them, to the officers of the Medical Society of Delaware for their interest and cooperation during the year, and to the physicians of Delaware as a group for the privilege of working with them during the year past.

Respectfully submitted,
LAWRENCE C. MORRIS, JR.
Executive Secretary

The report was accepted.

PRESIDENT SHANDS: Next we have reports of standing committees. These are all to be published. Some of them are to be read and some of them are to be read by title only. The first is the Budget Committee.

COMMITTEE ON THE BUDGET

Your Committee on Budget recommends adoption of the following budget for the year 1960:

Receipts		
Dues	$20,000.00	
Dinner tickets	750.00	
Dividends	650.00	
Contribution from D.S.M.J.	1,480.00	
AMA Reimbursement	85.00	
		$22,965.00
Disbursements		
Salaries		
Executive Secretary	$ 8,000.00	
Secretary	3,480.00	
Pay roll taxes	207.00	
		$11,687.00
Operations		
Journal subscriptions	$ 1,300.00	
Public Laws	200.00	
Committee on Medical Service and Public Relations	500.00	
Committee on Medicare Adjudication	50.00	
Committee on AMEF	150.00	
Other Committees	200.00	
Auditor	275.00	
Miscellaneous	200.00	
Woman's Auxiliary	100.00	
		$ 2,975.00
Office		
Rent	$ 2,000.00	
Printing	500.00	
Telegraph	500.00	
Miscellaneous	150.00	
		$ 3,150.00
Travel		
AMA Delegate	$ 375.00	
AMA — AMSEC Conference	265.00	
AMA — Public Relations Institute	150.00	
Guest Speakers	300.00	
Local	300.00	
Contingency	350.00	
		$ 1,740.00
Annual Meeting		
Printing	$ 200.00	
Steno-typist	300.00	
Clerical	45.00	
Janitorial	25.00	
Dinner and Supper	1,200.00	
		$ 1,770.00
Memberships, contributions		
Aces and Deuces (AMA)	$ 25.00	
Conference of President of State	25.00	
Medical Society Executive Association	10.00	

Delaware State Chamber of Commerce	50.00	
Delaware State Science Fair	50.00	
Institute for Organization Management ..	175.00	
		$ 335.00
Balance unbudgeted for contingency		$ 1,308.00

The Committee wishes to point out that, in view of this year's experimental annual meeting without technical exhibits, no revenue from technical exhibits has been budgeted for the coming year. Furthermore, the Committee wishes to draw attention to the substantial decrease in necessary expenditures for the annual meeting resulting from an absence of exhibitors. In the event that the Society's administration during 1960 wishes to reinstitute technical exhibition at the annual meeting, the Committee assumes that revenue from this source will balance the necessary additional expenditures, and return some surplus to the Society.

Respectfully submitted,
CHARLES LEVY, M.D., Chairman
FELIX MICK, M.D.
T. H. PENNOCK, M.D.
W. C. PRITCHARD, JR., M.D.
M. A. TARUMIANZ, M.D.

FROM THE FLOOR: What is the amount of money from exhibits that we are going to lose?

DR. LEVY: We budgeted $700 in 1959. Mr. Morris says we grossed $1,400 and netted about $700 last year.

PRESIDENT SHANDS: That was from how many exhibits?

EXECUTIVE SECRETARY MORRIS: It was 27 or 28, I forget which.

PRESIDENT SHANDS: Are there any other questions?

The report was accepted.

PRESIDENT SHANDS: The next report is that of Medical Education.

REPORT OF THE COMMITTEE ON EDUCATION

Since the last annual meeting the Committee's activity has largely been confined to two areas; one, local seminars held in various parts of the State, and the two-way radio seminars which started October 6. On December 3, 1958 a pediatric seminar discussing the care of premature infants was held at the Alfred I. duPont Institute. It is felt that this was a most successful seminar and many of the pediatricians in Delaware, including both Kent and Sussex Counties, attended. Other individuals, nurses, etc., interested in this particular program, also seemed to be enthusiastic about the meeting.

With the assistance of the Department of Continuation of Education of the Pennsylvania Hospital in Philadelphia a seminar was held in Milford on March 25, the program of which is attached. There were twenty-six registrants at this seminar, and from all reports received, it was one of our most successful educational efforts. There were in attendance seventeen practicing physicians from Sussex County, three from New Castle County, two from Kent County, and one from Maryland.

The question of the establishment of the two-way radio seminar which was approved at the last annual meeting of the State Society was held in abeyance for some months because of unavailability of funds to finance it. Fortunately, Smith, Kline and French have undertaken to assist in this important particular and the staff of the University of Pennsylvania and Pennsylvania Hospitals and associated medical schools have cooperated with the Department of Continuation Education of the Pennsylvania Hospital, Mr. Morris, our Executive Secretary, and our Committee so that these seminars were started on October 6. It required considerable effort on everybody's part to bring this about. You have all received notice of the program, a copy of which is attached for the Committee record. The Committee requests the support of all members of the Society in this pioneer method of education and hopes that all will be patient if we experience at first some growing pains. We hope that there will be a large continued attendance. We hope by your continued constructive criticism that the seminars themselves will steadily improve and be of real value in the field of post-graduate medical education.

Respectfully submitted,
LEWIS B. FLINN, M.D., Chairman
LAURENCE L. FITCHETT, M.D.
G. BARRET HECKLER, M.D.

A motion was made and seconded to accept the report of the Medical Education Committee.

The next report is the Editor's report on Publications.

PUBLICATIONS COMMITTEE REPORT OF THE EDITOR

In the past three years it has been attempted to change the format of the Journal so that it would be more pleasing and attractive to our readers and our advertisers.

In 1959 a most important step was obtaining the services of Mrs. Melita Phillips as assistant to the editor. Mrs. Phillips has had a great deal of experience in typography and in layout work. Comparison of issues of the Journal in the past two years will show a marked improvement in the past three months; this is entirely due to Mrs. Phillips' experience in this type of work.

The perennial complaint unfortunately still exists and that is the difficulty in obtaining material on time for the printer. As has been in effect for a number of years, different institutions throughout the state have certain issues of the Journal that are sponsored by them. They have the same month each year and therefore should know for an indefinite period in advance what their deadline is. It is felt by the editor that some degree of planning on the part of the institutions responsible for these issues could eliminate at least ninety percent of this problem. We are taking active steps in reminding these people on a monthly basis when their deadline is approaching.

We know that many of our readers and advertisers are pleased with the new format of the Journal.

Respectfully submitted,
A. HENRY CLAGETT, JR., M.D.

PRESIDENT SHANDS: The next report is the business report on publications.

PUBLICATIONS COMMITTEE REPORT OF THE MANAGING EDITOR AND BUSINESS MANAGER

Conclusion of operations, July, 1958 issue to Conclusion of operations, July, 1959 issue

Statement A	1957-58	1958-59
Balance, beginning of year	$ 5,837.62	$ 9,526.36
RECEIPTS		
Advertising	$24,121.56	$27,474.98
Subscriptions	1,339.54	1,332.04
Single copy sales	19.76	209.50
Royalties	.53	
Roster sales	16.00	24.00
SMJAB — share of profits	707.01	1,008.65
SMJAB — Refunded discounts		23.47
Interest	87.50	87.50
Reimbursed Conference Expenses	211.76	
Reimbursed plates		8.50
Second class permit return		10.00
Totals	$26,503.66	$30,178.64
DISBURSEMENTS		
Printing and mailing of Journal	$17,901.44	$19,888.74
Salaries	3,760.00	4,290.00
Taxes	63.90	92.40
Rent, including Prepaid Rent		1,250.00
Addressing of Journal	120.00	120.00
Copyrights	48.00	48.00
Personnel recruitment		43.20
Rights, Cartoon & Legal Column	175.00	80.00
Special printing (indices, inserts, roster)	187.18	175.00
Insurance	92.85	92.85
Plates	77.34	
Stationery, supplies, equipment	102.45	538.19
Special editing	65.00	
Credit investigation		3.00
Postage account	10.00	
Second class permit transfer		10.00
Staff travel & expense	211.76	270.95
Total	$22,814.92	$26,902.33

Checking Account

	1957-58	1958-59
Balance in beginning of year	$ 5,837.62	$ 9,526.36
Balance at the end of year	9,526.36	12,802.67
Surplus from operations	3,688.74	3,276.31

Savings Account

Statement B	1957-58	1958-59
Wilmington Savings Fund Society		
Balance, beginning of year	$ 3,626.53	$ 3,744.37
Interest	117.84	131.04
Balance end of year	$ 3,744.37	$ 3,875.41
Wilmington Trust Company		
Balance, beginning of year	$ 1,748.06	$ 1,765.54
Interest	17.48	35.66
Balance, end of year	$ 1,765.54	$ 1,801.20
Total in Savings Accounts end of year	$ 5,509.91	$ 5,676.61

Statement C — War Bonds — Purchase Date — 1942

	1957-58	1958-59
Balance — $3,502.38	$ 3,502.38	$ 3,502.38

Statement D — Summary

	1957-58	1958-59
Operating Funds & Reserve, beginning of year	$14,714.59	$18,538.65
Earned Surplus	$ 3,824.06	$ 3,276.31
Operating Funds & Reserve, end of year	$18,538.65	$21,981.66

Respectfully submitted,
M. A. TARUMIANZ, M.D.
Managing Editor
LAWRENCE C. MORRIS, JR.
Business Manager

PRESIDENT SHANDS: I believe that is a sizable figure for a journal of this size. It certainly is an indication of its excellent management. Are there any questions?

There was no response.

PRESIDENT SHANDS: As I understand it, this Journal is owned by the Society?

EXECUTIVE SECRETARY MORRIS: Yes.

PRESIDENT SHANDS: This is another asset.

The report of the Publications Committee was accepted.

PRESIDENT SHANDS: The next report is that of the Public Laws.

SECRETARY CANNON: This is a lengthy report but the Council felt it was important and all should hear it. I will read it as rapidly as I can.

REPORT OF THE COMMITTEE ON PUBLIC LAWS

(1) *Relations between medicine, optometry and opticianry*

Intra-professional relations in the field of eye-care have been a problem in Delaware, as in the rest of the country, over the years. Friction has arisen from the efforts of optometry, in the opinion of medicine, to achieve by legislation an expansion of its field of endeavor into the medical aspects of eye care, and to restrict, through interpretation of the optometric licensing acts, the prerogative of the physician to employ technicians, including opticians, in the conduct of his practice. Optometry has contended that medicine, by attempting to establish the status of the ophthalmic technician, has sought to attack the optometrist and prevent him from fulfilling his legitimate role in eye care.

No positive legislation has been submitted by optometry during the past year. In line with its policy of aiding the optician in establishing his legal status, the Medical Society of Delaware officially supported a bill submitted by the opticians of Delaware to provide for the licensing and regulation of the practice of optical dispensing. This bill was given a public hearing on the floor of the State Senate, and was supported by representatives of opticianry and of the State Medical Society. It was vigorously opposed by representatives of optometry, and has failed to reach the floor for a vote. The Committee doubts that the bill will pass in its present form, because of the strong and well organized opposition of optometry. It has been informally decided that the opticians may see fit to prepare a bill not requiring the endorsement of the Medical Society through the omission of implications requiring medical backing. The Committee thinks that establishment of legal ground for the technician per se might best be accomplished by suitable amendment to the Medical Practice Act and thus encompass the whole field of technical help to the medical profession.

Meanwhile, an effort has been made to cooperate with optometry in determining in just what areas we could arrive at a solution without legislative battles and without compromising the principles and prerogatives of either side. This state of relative truce is still in force and continued efforts are still being made to work out some program of cooperation.

(2) *Amendment of the Medical Practice Act*

During the presidential tenure of Dr. Baker, the Committee on Public Laws was charged by him to meet with the Medical Council of Delaware to review the Medical Practice Act and work up the necessary amendments to bring this act up to date. The Committee on Public Laws was never successful in arranging a meeting with the Medical Council. During the past year, the Committee on Public Laws discussed the necessity of such an amendment at length and reported this to a meeting of the Council of the Medical Society of Delaware. It was felt that amendments to the Medical Practice Act were required in two particular areas:

First, the Medical Council apparently has authority by the present Act to cancel or revoke a certificate of licensure for adequately stated causes. It does not have the authority, however, to suspend a certificate or place an offending person on probation as a temporary measure during investigation of an alleged transgression. It has been felt that such a provision adequately written would make for a stronger Medical Practice Act.

Second, there is no provision in the present Medical Practice Act to establish the status of the ancillary workers in the medical field. It has been suggested that an amendment to the Medical Practice Act include a statement expressing the following principle: That no legislation submitted in the interest of the limited practitioners in the para-medical fields should be construed to limit in any way the privileges or prerogatives of doctors of medicine as defined under the Act to utilize technicians in or out of their offices in the diagnosis and treatment of their patients, even though the duties and functions of these technicians might overlap those defined in the code of said limited practitioners.

No definite action has been taken, but recently we are informed that a committee to study this problem and prepare specific recommendations for the legislature for January, 1960, has been appointed by Judge Terry, Chairman of the Medical Council of Delaware. This committee includes, among others, the incoming president of the Medical Society of Delaware, and the chairman of the Committee on Public Laws.

(3) *The Medical Examiner System Versus the Coroner System*

This has been a tough problem and has many ramifications which will not be discussed here. Suffice it to say that early in the legislature's session, Senate Bill #40 was introduced to abolish the medical examiner system and Senate Bill #41 was introduced to define the functions of the coroner and coroner system. Members of the Public Laws Committee met with the Sussex County senator who introduced these acts, and with the members of the Sussex County Medical Society, and were successful in obtaining an official expression on the part of the Sussex County Medical Society in favor of the medical examiner system versus the coroner system. This carried with it ,however, certain suggestions for changes in the makeup and operation of the Board of Post-Mortem Examiners. These suggestions were relayed to the Board and were at least in part accepted in principle and to some extent put in operation. To implement some of these suggestions, the attorney general submitted certain bills, none of which have been successfully acted upon or passed. To this date, however, neither have the aforementioned Senate Bills 40 and 41 been passed. Senate Bill 265, weakening the medical examiner system in favor of the coroners, was passed by both Houses. The Society asked the Governor to veto the Bill, and he saw fit to do this. It became the responsibility of organized medicine to help uphold this veto.

(6) *Conference on Aging*

The AMA has repeatedly reminded the individual states that in considering the problem of the aged and the White House Conference on Aging, to be held in January, 1961, the medical profession should take an active and a leading part, even though the medical aspects of aging are by no means the only aspects to be considered. The Committee on Public Laws was in repeated contact with the Committee on Aging of the Medical Society of Delaware, and the latter Committee submitted a bill to establish a Delaware State Citizens' Committee on Aging. This bill passed both House and Senate, and has been signed by the Governor. It provides for a continuing study of the needs of the State's aged, the medical included, by a Commission Chaired by Clarence J. Prickett, M.D. Dr. Prickett is, of course, Chairman of the Society's Committee on Aging. The Committee on Public Laws anticipates that medicine will be well represented on the Commission, and looks forward to active cooperation between the Medical Society and the Commission.

(5) *Forand Bill H.R. 4700*

This Bill in the United States Congress had as its chief purpose to provide free hospitalization and free surgical care for all recipients of the retirement benefits of Social Security. This Bill was strongly opposed by the AMA and by the American Hospital Association. The Committee on Public Laws received assurance again from the representatives of the hospitals in this state that they were against this bill in principle. The Medical Society of Delaware asked to appear during the hearings in Washington, but due to the limited time allotted us, we deferred in favor of the AMA witnesses themselves. The many reasons why the Medical Society of Delaware was opposed to this Bill were outlined in a letter prepared by Dr. Shands with the help of this Committee and the Executive Secretary and sent to our representatives in the Congress and to the chairman of the committee conducting the hearings. The overwhelming opposition to this Bill resulted in its failure to come out of committee. The Committee anticipates a determined drive to pass legislation of this sort in 1960, and plans to oppose such attempts.

(6) *Naturopathic Physicians*

It has been observed that in the classified section of the telephone directory of Wilmington, there are three individuals who advertise themselves as naturopathic physicians. A letter of inquiry was directed to the office of the Attorney General of Delaware requesting an opinion con-

cerning the status of naturopathic physicians in Delaware. The essence of the opinion was that no provisions could be found in the laws of this state directly relating to the same but it was felt that other general laws would seem to prohibit this practice. It was recommended that either a warrant be signed for the individuals whom we might have probable cause to believe to be practicing medicine without a license under this guise or that such information be furnished to the appropriate police agency. No action has beeen taken on this topic.

(7) *Basic Science Law*

No action has been taken by the Committee during the current year to explore further the suggestion of creating a basic science law in the State of Delaware. The Committee still feels that consideration of such a move has considerable merit as a definite step in the direction of the best interest of the health of the citizens of Delaware, but recognizes that opinion is divided on this point.

(8) *Organization of Legislative Key Men*

On the theory that our interests will not best be served by closing the barn door only after the horse has escaped, an effort has been made to set up a medical legislative organization in the State of Delaware, comprised of legislative key men in each county who in turn will have direct organized contact with medical men in their respective areas, who in turn have personal contacts with members of the legislature or with candidate for office during times of election. The practical purpose of such an organization is twofold. First, to reach the necessary ears during the time of a legislative emergency, and second, to express our views and principles during election periods for individual information of the membership, so that local physicians might better evaluate candidates for election.

The Chairman of this Committee, the President-elect and the Executive Secretary recently attended an AMA-sponsored meeting in St. Louis at which the legislative problems of medicine were discussed before representatives of 49 states. It was the conclusion of the meeting that throughout the country medicine's opposition in legislative matters has been operating in a well organized and efficient manner and that steps must be undertaken better to educate the individual physician concerning the problems of organized medicine in legislative affairs, and to enlist more actively his support for our collective program. The Committee on Public Laws expects to develop this thesis during the coming year, probably through meetings at the county level for local physicians.

Respectfull submitted,
W. O. LAMOTTE, JR., M.D., Chairman
G. A. BEATTY, M.D.
JAMES BEEBE, JR., M.D.
J. L. FOX, M.D.
J. S. MCDANIEL, M.D.

PRESIDENT SHANDS: Dr. LaMotte is a dedicated individual on this subject and the work of this committee. I have never known one who has taken a deeper interest and has really gone to the heart of what it is all about in a more effective way. I certainly want to thank him as the President of your Society for what he has done and what his committee has done during the past year. I think Mr. Morris will wholeheartedly agree with the statements about Dr. LaMotte.

DR. MCGUIRE: Mr. Chairman, just as an individual member I would like to add a word of praise to the committee and suggest that all of us together, implement our knowledge more on the legislative activities on both a national and a State level because it is going to mean the survival of medicine as we know it today, based on our knowledge. I think this committee has done a fine job.

The report was accepted.

PRESIDENT SHANDS: The next is the report of the Committee on Scientific Work.

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work has been traditionally a standby committee and did not meet this year.

There is, therefore, no report.

JAMES T. METZGER, M.D., Chairman
N. L. CANNON, M.D.
J. A. ELLIOTT, M.D.

PRESIDENT SHANDS: The next is the report of the Women's Auxiliary.

ANNUAL REPORT — 1959 OF THE WOMEN'S AUXILIARY TO THE MEDICAL SOCIETY OF DELAWARE

The Woman's Auxiliary to the Medical Society of Delaware is now completing its 30th year. As president, it is my pleasure to submit this report on our activities and accomplishments for the year.

Delaware, with three counties, is 100 per cent organized. We have 279 members and had one death this year. All counties have shown a gratifying increase in activity and projects.

All counties participated actively in raising funds for A.M.E.F. The total collected to date is $579.54.

A "Today's Health" display was presented at our annual meeting. Auxiliary members, doctors, and dentists were solicited. A total of 75 subscriptions was obtained this year. The National "Today's Health" Committee announced that this year brings to a close the "Today's Health" project. The A.M.A. has decided to handle this phase of the work by sending a subscription to each physician paying A.M.A. dues.

The "Bulletin" is used primarily by our state and county officers and committee chairmen. Subscriptions total 26.

Our civil defense chairman distributed literature to the county chairmen, and several of our members assisted other civil defense organizations.

The state legislation chairman has forwarded to the county auxiliaries all national releases. Your president has received and read the "Washington Letter" and the "A.M.A. Secretary's Newsletter."

Safety has been stressed at our auxiliary meetings. Your president was a guest at a dinner meeting in Dover where Colonel Ferguson of the Delaware State Police spoke on safety. Your

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*Hirsch, H. A., and Finland, M.: *New England J. Med.* 260:1099 (May 28) 1959.

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safety chairman and I prepared an article on safety which was published in the "Delaware State Medical Journal."

Mental health received special emphasis as a project this year. New Castle County sponsored a booth at the Delaware State Hospital Fair. Kent and Sussex Counties volunteered to purchase toilet articles and make individual gift kits, which were distributed to the Stockley Hospital. We received from the area drug stores and the Coty Corporation a large donation of cosmetics and toilet articles. These were presented to the patients at the same hospital just before Easter.

A number of our members work regularly with the Volunteer Service Committee of the Mental Health Association, donating many hours of service at the state hospitals.

Auxiliary members have been very active in voluntary services. Individuals assisted in both the Delaware State Hospital and the Milford Memorial Hospital fairs. Members serve on hospital junior boards, man the hospital gift shops, and operate the gift carts to the patients' beds. Other services include assistances in clinics, acting as hostesses at state health units and the mobile chest x-ray survey, and cooperation with the mental health, cancer, heart, polio, T.B., and Red Cross drives. Some auxiliary mothers serve as Brownie leaders and as den mothers for the scouts. No survey was conducted this year of the total hours of service.

The Paramedical Careers Recruitment Committee notified each high school in the state of the scholarship program. The chairman planned a program for the Rotary Club of Wilmington for whom she and her committee screened and selected applicants to receive the nurses' scholarships sponsored by the Rotary Club of Wilmington.

An excellent article on "The Auxiliary's Challenge to Provide Nurses for a Changing World and a Growing Nation" was prepared by our state chairman, and was accepted for publication in the state medical journal. Our state chairman also prepared and placed a poster display in a Wilmington department store during Medical Education Week.

The Kent County auxiliary members gave a tea in Dover honoring all Future Nurses Clubs in Kent County. The Kent County auxiliary annually presents an award to the outstanding student in each high school's Future Nurses Club in Kent County. Each of our nursing schools in Delaware cooperated in the program. The recruitment has experienced an excellent year, and many ideas are being explored to make next year even more rewarding.

Since assuming the presidency in October, 1958, I have traveled 3,444 miles on auxiliary business. I have attended the state meetings of Maryland, New Jersey, and Pennsylvania; the annual conference for presidents in Chicago; the Pennsylvania mid-year conference in Harrisburg; and the annual meeting in Atlantic City in June.

On the state level, there have been four executive committee meetings and one directors' meet- I have attended all of the Kent County auxiliary meetings and was guest speaker at four other meetings. Presidential letters were sent periodically to various state officers and chairmen.

In February, 1959, the Woman's Auxiliary received a check in the amount of $100 from the Medical Society of Delaware, for the purpose of helping with auxiliary expenses. We are extremely grateful for this donation.

As we come to the close of our 30th year, I would like to convey my sincere appreciation to my board of directors, officers, committee chairmen, and the convention chairman and her committee.

I consider it a very special privilege to have served as your president. The experience I have gained and the friendships I have formed have made it indeed a very rewarding experience.

Respectfully submitted,
MRS. HEWITT W. SMITH, President

PRESIDENT SHANDS: A motion is in order with thanks. Do I hear such?

A motion was made and seconded to approve the report of the Woman's Auxiliary.

PRESIDENT SHANDS: I sounds as though the Woman's Auxiliary has been very active, and Mrs. Smith has done a fine job.

The report was accepted.

PRESIDENT SHANDS: Next we have reports of Special Committees. First is the Advisory Committee to the Woman's Auxiliary.

REPORT OF THE ADVISORY COMMITTEE WOMAN'S AUXILIARY

Your Advisory Committee has held no formal meetings. Your chairman has held numerous informal conferences with the president of the Woman's Auxiliary concerning information and procedure relating both to Auxiliary and Medical Society affairs.

We anticipate a well prepared Auxiliary session.

Respectfully submitted,
HEWITT W. SMITH, M.D., Chairman
L. C. MCGEE, M.D.
J. V. CASELLA, M.D.
R. F. LEWIS, M.D.

PRESIDENT SHANDS: The next report is the American Medical Education Foundation.

COMMITTEE ON AMERICAN MEDICAL ASSOCIATION FOUNDATION

The Committee on the American Medical Education Foundation reports contributions of $2,624.54 for the period January 1, 1959 through August 31, 1959, and of $5,226.59 for the period September 1, 1958 to August 31, 1959. The Woman's Auxiliary from all three counties has been inflfluential in contributing a good percentage of this total. The Committee wishes to congratulate the Auxiliary and thank the members for their excellent work.

There will be two more letters reminding members to contribute this year. We expect a good response to these requests. It is the opinion of the Committee that solicitation by mail and through the County Society meetings is the most acceptable to the members.

The National Committee requested us to consider collections by means of an assessment added

to the State Society dues. This did not meet with favor for the following reasons: AMEF contributions are voluntary — an assessment is not; contributions in Delaware generally exceed the amount an assessment would raise; comparatively, Delaware ranks well when compared to other states in total amount and in percentage contributing.

Our President, Dr. Shands attended the National AMEF meeting in Chicago in January. The Committee expresses its thanks to Dr. Shands for representing us at that meeting.

Respectfully submitted,
J. L. FOX, M.D., Chairman
J. J. DAVOLOS, M.D.
F. R. EVERETT, M.D.
J. R. KERRIGAN, M.D.
R. L. KLINGEL, M.D.
W. W. LATTOMUS, M.D.
F. O. POOLE, M.D.
S. W. RENNIE, M.D.

PRESIDENT SHANDS: We have done quite well in the A.M.E.F., thanks to Dr. Fox and his predecessors. We rank with the best of the States. I think we are right in not having an assessment. If an assessment is put on, I think it will discourage any additional giving, and we will wind up with less in the end.

One of the things which has been worked out is that if we want to give and we are solicited by our own medical school or other medical schools, we can give to this medical school through the A.M.E.F. A great many of you have been giving for a number of years to your own school through the Alumni, and if there is any problem about wanting to know whether you can or cannot give through the A.M.E.F., get in touch with me or Mr. Morris because I know we can work it out. But that was one of the things I know discouraged giving through the A.M.E.F. for a great many years.

PRESIDENT SHANDS: Is there any discussion?

DR. DEWEES: I would like to ask whether the figure takes into account those of us who do contribute to our own alma mater directly. I was asked whether I did by mail and indicated that I did. But I would guess that there are a number who did not contribute to the A.M.E.F. but contribute directly. Is that figure taken into account?

PRESIDENT SHANDS: That is what they are trying to get straightened out. You can give either way. Give directly to A.M.E.F. if you are approached by your home school, and of course the school gets the full amount. There is nothing taken out for overhead. But they are trying to work out some system that the schools will report to A.M.E.F. and that will be credited to the State.

Mr. Morris, is that correct?

EXECUTIVE SECRETARY MORRIS: I think that is right. The difference is that A.M.E.F. is in a position to go to various foundations, corporations, what not, and say, "We have been able to raise this much," and when contributions go directly to the school, at least under the present system the contributions are not taken into account. With A.M.E.F. there is a leverage factor. The money you give generates more money because it can be used as concrete support from doctors for medical schools.

PRESIDENT SHANDS: That would be my suggestion. This year for the first time I am going to give through the A.M.E.F., although I am approached each year from my own school as well as the school where I took my hospital work.

The report was accepted.

PRESIDENT SHANDS: The next report is the Committee on Alcoholism.

REPORT OF COMMITTEE ON ALCOHOLISM

Although no accurate census of the alcoholics in the population of Delaware is available, data from four state-supported institutions and two agencies give evidence that alcoholism is a serious problem in the State. The State Board of Corrections, the Delaware State Hospital, the State Welfare Home and Hospital for the Chronically Ill, the Governor Bacon Health Center have provided residential care and treatment for alcoholics in the fiscal year 1958-59. The Mental Hygiene Clinics of Delaware have given outpatient treatment to alcoholics. This report will present information suggestive of the incidence of alcoholism in the State. It will also indicate some of the efforts being made to cope with the problem.

The Board of Corrections, State of Delaware. According to the records of the State Board of Corrections for the fiscal year 1958-59, the total number of commitments in Delaware on a charge of Drunkenness was 2,019. The total number of commitments on the charge Driving Drunk was 968. These two charges represent a total of 2,987 commitments of which 2,795 were males, 192 females.

The total number of commitments to the New Castle County Correctional Institution in 1958-59 on the charge of Drunkenness was 891. The total number of commitments to this institution on the charge Driving Drunk was 469. There were, therefore, a total of 1,360 commitments to the New Castle County Correctional Institution on these two charges involving drinking. Of these 1,268 were males, 92 females.

The Delaware Safety Council reported on December 31, 1958, that in 15 of the 71 fatal accidents occurring in the calendar year 1958 (which includes six months of the period for which the other data are given) both speeding and drinking were reported. Drinking on the part of the driver was reported in 6 other accidents. In still another accident during this year, a pedestrian who had been drinking was killed. In 22 of he 71 fatal accidents during 1958 drinking was a factor.[1]

A program of weekly meetings under the sponsorship of the Alcoholics Anonymous is in operation for males in the three correctional institutions under the jurisdiction of the State Board of Corrections. At the Del Castle Farm of the New Castle County Correctional Institution the average attendance has been 80. At the Kent County Correctional Institution there had been an average of 60 and at the Sussex County Correctional Institution an average of 100. It should be said that these meetings are open to any inmates. Some who attend may not be alcoholics. At the New Castle County Correctional Institution there is one highly screened group of alcoholics who have been meeting regularly with a counselor.

[1] *Wilmington Morning News*, "Speed, Drinking Blamed In 39 of 71 Fatal Accidents," Wilmington, Delaware, Thursday, January 15, 1959.

The attendance in this group has averaged 8. The inmates who attend these meetings must sign a request to be included in the group. It is thought, therefore, that this group of inmates is definitely motivated toward receiving help. In the Women's Building at the New Castle County Correctional Institution A.A. meetings are not held on a regular basis. Instead, female members of A.A. work with individual women at the suggestion of the Supervisor of the Women's Prison.

Delaware State Hospital. Alcoholics who are psychotic or too severely disturbed emotionally to remain in the community are among the patients treated at the Delaware State Hospital. During the fiscal year 1958-59, 35 alcoholics (25 males, 10 females) were received as first admissions to a psychiatric hospital. A total of 24 (22 males, 2 females) were readmitted during the period being considered. One of the patients included in the total number of admissions was committed to the Delaware State Hospital by a court. Fifteen alcoholic patients left the hospital on Trial Visit status during the year. Twelve others were discharged. On June 30, 1959, a total of 67 alcoholics (54 males, 13 females) remained in residence.

The ages of the alcoholic patients admitted and readmitted to the Delaware State Hospital in 1958-59 ranged from 21 to over 65 years. Thirty-six per cent of the males received as first admissions in the past fiscal year were between 21 and 40 years of age. Fifty per cent of the female first admissions in this period were within this age range. Of the total number remaining in residence at the end of the fiscal year (67 patients) 71.6 per cent ranged in age from 36 to 55 years.

Mental Hygiene Clinics. During 1958-59 the Mental Hygiene Clinics of the State received a total of nineteen patients (13 males, 6 females) were diagnosed as alcoholics. Of this number 12 (9 males, 3 females) received treatment. Four of this number (two of each sex) withdrew from treatment too soon for their condition to have been much affected. Two males were discharged improved. Six patients (5 males, 1 female) were discharged unimproved. Five patients (4 males, 1 female) were admitted for diagnosis only. Two female patients were recommended for psychotherapy but refused treatment. One male discharged unimproved and one female received for diagnosis only were referred for residential treatment at the Governor Bacon Health Center.

The State Welfare Home and Hospital for the Chronically Ill. Each year a small number of the patients admitted to the State Welfare Home and Hospital for the Chronically Ill, at Smyrna, Delaware, have chronic alcoholism as a part of their diagnosis. Eight male alcoholics were admitted during the fiscal year 1958-59. They ranged in age from 38 to 66 years. No female alcoholics were admitted in this period. Four males classified as alcoholics were discharged and transferred to the Governor Bacon Health Center during the fiscal year.

The Governor Bacon Health Center. One of the services of the Governor Bacon Health Center is the Alcoholic Rehabilitation Unit, which provides residential care and treatment for alcoholic patients who are not frankly psychotic. During the fiscal year 1958-59, a total of 108 alcoholic patients (91 males, 17 females) were admitted to the Governor Bacon Health Center. Of this number a total of 19 (18 males, 1 female) had been previously a patient in a psychiatric hospital. One male patient was transferred to the Governor Bacon Health Center directly from the Delaware State Hospital. There were 52 readmissions (44 males, 8 females). Twenty-two patients readmitted in the past fiscal year (42.3 per cent of the total number readmitted) had been patients in the Alcoholic Rehabilitation Unit at least twice previously. The total number of alcoholic patients admitted for residential treatment at the Health Center during 1958-59 was 161 (136 males, 25 females). The largest number of referrals for alcoholic patients admitted for the first time to the Governor Bacon Health Center were made by members of Alcoholics Anonymous — a total of 40 (34 males, 6 females). The second largest number of referrals were received from physicians, a total of 43 patients (35 males, 8 females).

A total of 29 alcoholic patients (26 males, 3 females) were committed by courts to the Alcoholic Rehabilitation Unit for periods ranging from 30 to 90 days. The largest number of commitments was made by the Family Court of New Castle County (13 including 11 males, 2 females). The Municipal Court for Wilmington made the second highest number of commitments — a total of 10 (9 males, 1 female).

A total of 147 alcoholic patients (124 males, 23 females) were discharged from residential treatment during the past fiscal year. Of the number discharged, a total of 101 patients (86 males, 15 females) were discharged improved. A male and a female were discharged as having received maximum benefit, and one male as slightly improved. Nineteen patients (13 males, 6 females) were discharged unimproved and against medical advice. An additional 11 males were discharged unimproved but with permission. This includes one male patient who became psychotic and was transferred to the Delaware State Hospital. Thirteen patients (12 males, 1 female) were discharged from the books as AWOL, having left without the knowledge or permission of the personnel of the Health Center.

Two males admitted during the fiscal year were addicted to drugs as well as to alcohol. One was discharged improved. The other died from alcohol intoxication, delirium tremens due to alcohol and bromides, edema of lungs due to poisoning (alcohol and bromides), cerebral edema and bronchopneumonia.

Two other male alcoholics died during the fiscal year. The death of one was due to infarction of the myocardium due to arteriosclerotic coronary thrombosis. The death of the third alcoholic male was due to Laennec's cirrhosis with hemorrhage and bronchopneumonia. The ages of these three patients at death were 46, 63, and 56 respectively.

Conference on Alcoholism. Two members of the Staff of the Alcoholic Rehabilitation Unit of the Governor Bacon Health Center and two members of the Wilmington Alcoholics Anonymous attended the Northeast States' Conference on Alcoholism, which was held in New Haven, Connecticut, on May 18-20, 1959. The Conference was sponsored by the Connecticut Department of Mental Health, the Connecticut Commission on Alcoholism, and the United States Public Health Service. The Conference Program included discussion of topics pertinent to the treatment and rehabilitation of alcoholics in residential and outpatient facilities.

Conclusion. The data presented above indicate that alcoholism is a problem of serious proportion in Delaware. It represents wastage of human potentialities. The preceding information gives only a partial picture of the situation in the State. Perhaps the assistance of some of the community agencies like the Family Society for Northern New Castle County, the State Department of Public Welfare, the Family Court might be elicited to furnish from their records information regarding the number of cases in their active case loads having alcoholism as one of the problems affecting family relationships.

A half-way house or some other such facilities to which homeless alcoholics could go after discharge may help to reduce the incidence of recidivism. Too frequently the alcoholic patient on discharge returns to his former lodgings and is immediately surrounded with the drinking companions of his pre-hospital association. The rehabilitation of the alcoholic patients discharged from the Governor Bacon Health Center might be made available for a social worker to work exclusively with the alcoholic patients. This worker could assist the patients in finding an environment more conducive to sobriety. At the same time the families of alcoholic patients, through case work, might gain understanding of the patient's problems and needs and develop techniques for assisting him in his efforts at rehabilitation.

Finally, the Special Committee on Alcoholism is of the Opinion that the problem of alcoholism in any community is the responsibility of all community agencies and professional societies. Therefore, a coordinated effort of medical personnel and community agencies is necessary for preventive measures as well as treatment and rehabilitation of the alcoholic. It behooves the Medical Society of Delaware to take the initiative toward a coordinated approach to the problem of alcoholism in Delaware.

Respectfully submitted,
M. A. TARUMIANZ, M.D., Chairman
BRUCE BARNES, M.D.
H. T. MCGUIRE, M.D.
C. J. PRICKETT, M.D.

PRESIDENT SHANDS: I think we can't pass over this report without a word about our departed member, George Gehrmann, who was so interested in furthering the research of alcoholism in the State.

DR. MCGUIRE: I think it would be proper and appropriate for the State Society to take cognizance of the interest and the intelligence and the dedication that Dr. Gehrmann showed in this problem. He was the individual who hired a member of A.A. and brought him here and put him in the employ of the du Pont Company, rather surreptituously. That member in turn, through the facilities of this building started the first A.A. group in this community, in Delaware.

We are all aware that A.A. has modified our historic attitude, bigotry or prejudice in this general problem of alcoholism because it has shown that drunks can stand up and go back and meet their economic, social and cultural needs.

I would like, Mr. Chairman, to formally move that this House of Delegates send a note of recognition and appreciation to Dr. Gehrmann's widow for the significant contribution he has made in this medical, emotional and psychological problem.

PRESIDENT SHANDS: I would say this should be in the form of a resolution, and I can tell you no one will more deeply appreciate that thought than Mrs. Gehrmann. She was 100 per cent behind everything her husband did. So do you put that in the form of a motion?

The motion was carried and the report accepted.

PRESIDENT SHANDS: The next report is that of the Grievance Board.

REPORT OF THE GRIEVANCE BOARD OF THE MEDICAL SOCIETY OF DELAWARE

Mr. President and Members of the House of Delegates:

Your Grievance Board is pleased to report that no cases have been referred to us during this past year and therefore we had no occasion to take any action.

Respectfully submitted,
E. R. MAYERBERG, Chairman
BRUCE BARNES, M.D.
ROGER MURRAY, M.D.
H. W. SMITH, M.D.
M. A. TARUMIANZ, M.D.

PRESIDENT SHANDS: The next report is that of the Committee on Aging.

Editorial Note: This report was not read at the time. It was deferred to be part of the seminar presented on Thursday, October 15th.

A report on this subject will be presented in connection with a Panel Discussion, "Growing Older—The Medical, Mental and Social Problems of the Elderly" in an early issue of the JOURNAL.

PRESIDENT SHANDS: The next committee report is that on Maternal and Infant Mortality.

REPORT OF COMMITTEE ON MATERNAL AND FETAL MORTALITY (1958)

During the year 1958 there were a total of 11,754 live births in Delaware. There were four maternal deaths in 1958, giving a .34 maternal deaths per thousand deliveries, compared to .36 in 1957. The four maternal deaths shall be designated as A,B,C and D.

Case A—Age 17, colored female. The cause of death in this case was a direct obstetrical, (A)—hemorrhage. It would appear that this was due to patient's lack of prenatal care and most probably the patient came to delivery with an inadequate hemoglobin, with bleeding accompanying delivery, went into irreversible shock in spite of heroic efforts.

Case B—Age 31, colored female. This patient died of Peritonitis following septic complete abortion. The cause of death. Direct Obstetric, (C)—Infection. No physician responsibility involved.

Case C—Age 39, white female. The cause of death in this situation was post-operative delayed circulatory collapse following a Caesarean Section. No further information was supplied to the committee, so the classification here is left as undetermined due to insufficient information.

Case D—Age 29, white female. This patient went into spontaneous premature labor at approximately six months, and died of anoxia following

aspiration of vomitus. Classification, Direct Obstetrical, (E)—Anesthesia. This is classified as one in the preventable category.

The deaths as they have occured for the year 1958 in the State Of Delaware again point up the fact that the cause of maternal deaths fall in the pattern as follows:

i.e. 1—*Hemorrhage*
2—*Infection*
3—*Anesthesia*

We must therefore again renew our efforts for improved careful prenatal and natal care. To be ever on the alert for patients going into spontaneous labor with full stomachs, because of the tremendous danger involved in a patient undergoing general anesthesia for delivery with undigested food in the stomach. Continued vigilance must be maintained at all times in the care of the pregnant patient.

The committee wishes to acknowledge our thanks to Mr. Lawrence C. Morris Jr., Executive Secretary of the Medical Society of Delaware, the Delaware State Board of Health, and the cooperation of all the physicians interested in improving maternal and infant care in Delaware.

REPORT ON INFANT MORTALITY — 1958 —

The Committee on Infant Mortality has continued to study the neonatal deaths occurring during the first seven days of life.

Study Sources

The form for recording information on neonatal deaths was, for the most part, filled in by the physician responsible for the care of the infant. The members of the committee obtained the lacking data from the hospital charts. The statistics are found in Tables I and II. The death rates for the five year period 1954 to 1958 are found in Table III.

Discussion

For the past three years, the rate for the State of Delaware has been about 14.5 deaths / 1000 live births, after having been 18.1 in 1954. It was hopefully thought that this indicated improvement, but 1958 brought a rate of 17.7, with a rate of 15.9 for the five year period, 1954 to 1958. Therefore there is no statistically significant change. Also, there is no real change for any individual hospital. This seems discouraging, but at least we can report that two of the Wilmington hospitals and all of the Sussex and Kent County hospitals hold regular discussions of the neonatal deaths and most of the preventable factors listed for the deaths at these hospitals have been handed down as the opinion of the staff of the particular hospital. Now that the physicians are becoming critical of themselves we may see some progress. The autopsy percentage has averaged 45 per cent and should be much better.

Discussion of deaths with preventable factors

Case I. 2 lb. 3 oz. negro male delivered by explosive force while the resident was donning a gown. The baby shot out to the end of the cord, which separated from the baby. The baby died of intracranial hemorrhage.

Case II. 5 lb. 11 oz. white male—lived four days. There was no post mortem examination, but it was the opinion of the staff that this death was the result of poor feeding technique.

Case III. 8 lb. 1 oz.—negro female delivered by Cesearean section. Baby reported to be in fair condition. Feedings were started on the second day and were taken poorly. Staff opinion was that there should have been a pediatric consultation for an infant who was that sick. Prenatal care was also inadequate.

Case IV. 4 lb. 6 oz. Precipitous delivery at home. No prenatal care. Intracranial hemorrhage was the cause of death.

Case V. 1 lb. 7 oz. white female. Mother was hyperthyroid with no care during first five months of pregnancy.

TABLE I

	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Total live births	2688	2288	1903	947	191	1244	975	374	500	451	193	11754
Deaths in first 7 days	35	47	41	19	3	21	14	6	8	7	7	208
Corrected deaths first 7 days	35	46	39	19	4	19	14	6	8	7	11	208
Deaths/1000 L.B. first 7 days	13.0	20.1	20.5	20.1	20.9	15.3	14.4	16.1	16.1	15.5	57	17.7
Deaths/1000 L.B. first 24 hours	8.9	12.2	12.6	6.3	20.9	9.6	10.3	10.7	4.0	8.9	51.8	11.4
Deaths in first 7 days—weight over 1000 gms.	24	27	20	11	2	12	8	2	6	4	5	121
Deaths/1000 L.B. first 7 days over 1000 gms.	8.9	11.8	10.5	11.6	10.5	9.6	8.2	5.3	13.2	8.9	25.9	10.3
% deaths previable 500-1000 gms.	31.4	41.3	48.7	42.1	50	36.8	42.8	66.6	25	42.7		
% deaths viable prematures 1000-2500 gms.	45.7	37.0	35.9	36.8	50	52.7	35.8	33.3	25	42.8		
% deaths over 2500 gms.	22.9	21.7	15.4	21.1	0	10.5	21.4	0	50	14.3		
Inadequate prenatal care	5	8	13	11	0	3	5	4	1	0	7	50

TABLE II

Cause of death	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Undetermined	13	23	18	9	3	13	6	3	3	4	8	103
Hyaline membrane	4	6	4	1		1						16
Congenital anomalies	5	4	4	4		3	1			1		22
Intrauterine anoxia	5	1	5	1	1		2	2	2	1	1	21
Intracranial hemorrhage	3	8	2	1		2	3	1	2		2	24
Erythroblastosis fetalis	3	2	1	2								8
Pulmonary hemorrhage	1	1	1							1		4
Sepsis	1		1									2
Bronchopneumonia		1	2	1			1		1			6
Aspiration of milk			1									1
Purpura							1					
Total	35	46	39	19	4	19	14	6	8	7	11	208
% Undetermined	37.2	50	46.2	47.3	75	68.4	42.9	50	37.5	57.2	72.7	49.5
Autopsies	19	28	24	4	0	13	8	1	6	2	0	105
% Autopsies	54.4	59.6	58.5	21	0	61.8	57.2	16.7	75	28.6	0	50.5

TABLE III
1954 - 1959

	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Total live births	14076	10594	8033	4273	841	5008	4550	1865	2219	1767	1919	55145
Corrected deaths	182	196	133	67	21	68	66	37	38	21	46	875
Deaths/1000 L.B.	12.9	18.5	16.6	15.7	25.0	13.5	14.5	19.8	17.1	11.9	24.0	15.9
Deaths over 1000 gm.	120	128	75	43	12	43	42	20	30	13		
Deaths/1000 L.B. weight over 1000 gm.	8.5	12.1	9.3	10.1	14.2	8.6	9.2	10.7	13.5	7.3		

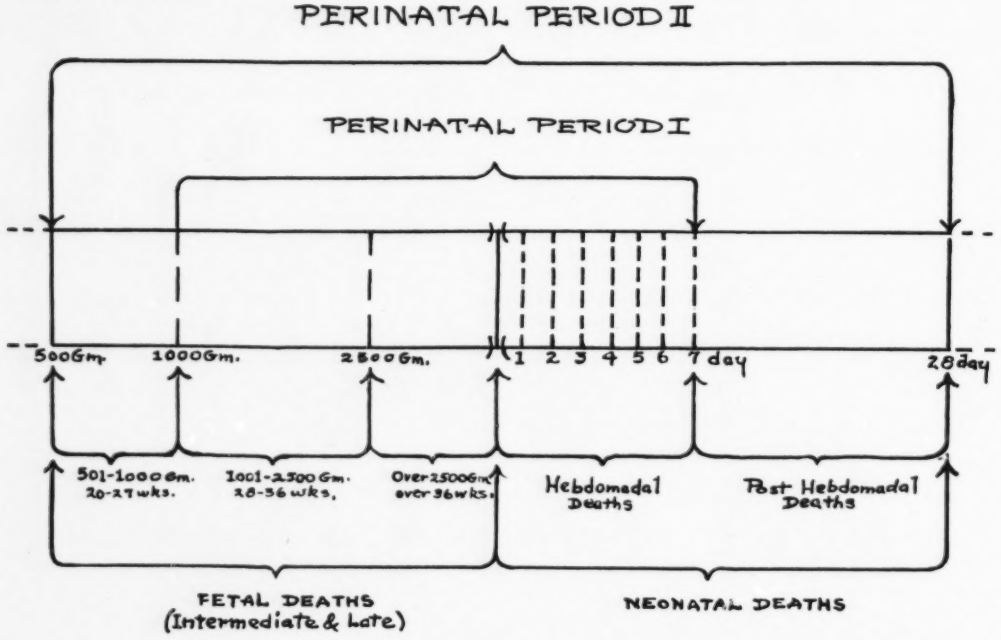


TABLE 5. APGAR RATING

SIGN	0	1	2
Heart rate	Absent	Slow below 100	Good Over 100
Respiratory effort	Absent		
Muscle tone	Limp	Slow irregular	crying
Response to catheter in nostril (tested after oropharynx is clear)	No response	Some flexion of extremities Grimace	Active motion Cough or sneeze
Color	Blue, pale	Body pink, extremities blue	Completely pink

Case VI. 4 lb. 14 oz. negro male. Subarachnoid hemorrhage was the cause of death. Mother is a diabetic and had inadequate prenatal care.

Case VII. 5 lb. 13 oz. Normal while in hospital. Returned 10 hours after discharge with cyanosis and milk coming from the nostrils. Postmortem examination revealed aspiration pneumonia.

Case VIII. 3 llb. 3 oz. cyanotic at birth and respirations were delayed and irregular. Large amount of mucus. Was eating well. Died on the 4th day. Attending physician thought baby aspirated.

Case IX. 6 lb. 8 oz. erythroblastosis. Air embolism during exchange transfusion. Catheter was inserted 10-12 cm. into umbilical vein. After withdrawing the first 20 cc., catheter was open to the air and the blood in the tube disappeared, as though "sucked into the baby.

The Committee on Maternal and Child Care of the American Medical Association has prepared a Guide for the Study of Perinatal Mortality and Morbidity.

In order to standardize the reporting of perinated mortality, the following chart indicates quite well the subdivisions of neonatal and fetal deaths.

Medovoy and Biggs[1] of Winnepeg have outlined a program for preventability that we should like to use as a basis for discussion of Delaware's needs.

1. Increased facilities for prenatal care. Twenty to twenty-five percent of all the hebdomadal deaths in Delaware have been babies of mothers with no prenatal care or inadequate prenatal care.

2. Concentration of attention on babies who are in difficulty at birth. The Apgar method of assessing the condition of the baby at birth has been widely used and has been instituted as a routine in several of the Wilmington hospitals. The baby is rated 0, 1, or 2 on each of five clinical signs with a top score of 10. Infants rated 6-10 usually have no difficulty. Those rating 1-5 need careful supervision during the first forty-eight hours. Some of these will have no difficulty and will be normal babies, but many will prove to have trouble due to such conditions as anoxia, infection, or congenital anomalies.

3. Early recognition of infection. Most neonatal infections are acquired inutero. A high index of suspicion is the key to prompt diagnosis. Any infant that is listless, feeds poorly, has respiratory difficulty, or has jaundice in the presence of any of the former three, shouldl be suspected of infection. Sepsis must be anticipated and prophylactic antibiotics started at birth in any of the following conditions.

a. Premature rupture of membrances for 18 hrs. prior to delivery.
b. Prolonged, difficult labor, especially if there has been manipulation or instrumentation.
c. Artificial induction of labor.
d. Murky amniotic fluid.
e. Maternal febrile illness preceding or during labor.
f. Delivery outside of labor room under conditions less than ideal.

4. Alert, well trained personnel.

5. Specialized care of conditions which commonly cause neonatal deaths.

a. Respiratory distress syndrone.
b. Congenital malformations.
c. Erythroblastosis.

Respectfully submitted,
F. S. HASSLER, M.D., Chairman
B. F. BURTON, M.D.
K. L. ESTERLY, M.D.
L. I. FITCHETT, M.D.
A. M. GEHRET, M.D.
P. C. TRICKETT, M.D.
R. O. Y. WARREN, M.D.
A. H. WILLIAMS, M.D.

Report accepted.

PRESIDENT SHANDS: The next report is on Military and Veterans Affairs.

REPORT FROM THE COMMITTEE ON MILITARY AND VETERANS AFFAIRS

There has been no business before the Committee this year so that there have been no meetings of this Committee and it has therefore been inactive.

Respectfully submitted,
C. F. RICHARDS, M.D., Chairman
O. A. JAMES, M.D.
S. W. ROSE, M.D.
F. S. SKURA, M.D.
V. D. WASHBURN, M.D.

Report accepted.

PRESIDENT SHANDS: The report on Medical Economics is next.

1 Medovy, H. and Briggs, J. N.,: Reduction in Neonatal Mortality: The Present and the Future. Pediatric Clinics of North America. May, 1959; 259-277.

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

In March, the Council of the Medical Society of Delaware referred to the Committee on Medical Economics the following question: "Regarding closed panel systems, what is or will be the attitude of the State Society regarding physician participation in those systems of medical care which restrict free choice of physician?"

Two meetings of the Committee were called prior to the Council's stated reporting date of April 9. In both cases, the Chairman was unable to establish a quorum, and feels it inappropriate to submit the following conclusion as a committee report. Having studied the report of the American Medical Association's Commission on Medical Care Plans, the Chairman is in agreement with the conclusion of this Society's Committee on Medical Service and Public Relations, to the effect that however desirable free choice of physician may be, good medical care *can* be rendered in its absence. Therefore, I recommended to the Council that Society's attitude be one of cooperation unless such cooperation is obviously not deserved. The closed panel plan is legal and is here to stay, and your Chairman suggests that the interests of everyone concerned will best be served by assisting whatever closed panel plans may develop in Delaware to provide the best possible medical care. The Chairman further suggests that the Society be alert for the institution of such plans in this state, so that sound intra-professional relationships can be developed, if warranted, from the start, for the benefit of all concerned and particularly of the patient.

Respectfully submitted,
LESLIE W. WHITNEY, M.D.
C. J. PRICKETT, M.D.
E. S. RESNICK, M.D.
E. L. STAMBAUGH, M.D.
O. N. STERN, M.D.

Report accepted.

SECRETARY CANNON: This is Dr. Gordy's report as Chairman of the Committee on Medico-Legal Affairs.

REPORT OF COMMITTEE ON MEDICO-LEGAL AFFAIRS

The Committee on Medico-Legal Affairs, together with its counterpart from the Delaware Bar Association, presented the Fourth Annual Medico-Legal Symposium at the Alfred I. du Pont Institute on Sunday, February 22, 1959. The facilities of the Institute were made available to the combined committee through the courtesy of Mrs. Alfred I. du Pont and Alfred R. Shands, Jr., M.D., Director of the Alfred I. du Pont Institute.

Co-chairmen of the meeting were the Honorable Daniel L. Herrmann, chairman of the Medico-Legal Committee for the Delaware Bar Association, and Philip D. Gordy, M.D., chairman of the Medico-Legal Committee for the Delaware State Medical Society.

The group was welcomed by Dr. Alfred R. Shands, Jr., Director of the Alfred I. du Pont Institute and President of the Medical Society of Delaware, and H. Albert Young, Esq., President of the Delaware Bar Association. The morning program consisted of a very interesting and informative discussion of the comparative merits of various plans that have been adopted for the presentation of impartial medical testimony. This discussion was presented by Dr. William J. Curran, Director of the Law-Medical Research Institute of Boston University. The discussion was extremely interesting and informative and provoked many questions from the combined audience. Following this, a panel discussion took place on the problem of impartial medical testimony, particularly as it relates to the local medico-legal situation. Dr. James T. Metzger was the moderator of the panel, and the panelists were: David F. Anderson, Esq., Thomas Herlihy, Jr., Esq., David J. King, M.D., Harold Leshem, Esq., and Theodore B. Strange, M.D.

Following luncheon, the afternoon session was devoted to a demonstration of trial tactics in a case of traumatic neurosis. The trial team was drawn from local physicians and attorneys and consisted of: Irving Morris, Esq., Attorney for Plaintiff, Rodney M. Layton, Esq., Attorney for Defendant, H. Albert Young, Esq., Judge, Albert L. Ingram, Jr., M.D., Medical Witness.

Following the trial tactics demonstration, a panel discussion was presented in which various aspects of this particular medico-legal problem were explored. The panel consisted of: H. Albert Young, Esq., Albert L. Ingram, M.D., Jerome Kay, M.D., Rodney M. Layton, Esq., Irving Morris, Esq., Dewey A. Nelson, M.D. Following the panel discussion, the meeting was adjourned at 3:30 p.m.

The meeting was considered to be extremely informative and valuable, and it was felt that further sessions should be undertaken. Possibly these sessions might be in the form of smaller groups meeting several times during the year.

A review of the financial picture revealed a balance from the previous seminar of $133.50. Total disbursements for the 1959 seminar were $445.77. Receipts totaled $564.00. Cash on hand as of March 4, 1959, was $251.73.

The Committee wishes to thank all of those whose efforts resulted in the eminently successful Fourth Annual Medico-Legal Symposium.

Respectfully submitted,
PHILIP D. GORDY, M.D., Chairman
W. L. BAILEY, M.D.
JAMES BEEBE, JR., M.D.
S. S. BJORNSON, M.D.
J. L. FOX, M.D.
O. A. JAMES, M.D.
J. S. MCDANIEL, JR., M.D.
M. B. PENNINGTON, M.D.
O. J. POLLOK, M.D.
H. S. RAFAL, M.D.
V. D. WASHBURN, M.D.

Joint Committee on Medico Legal Affairs
of the Medical Society of Delaware
and the Delaware Bar Association
Wilmington, Delaware

Gentlemen:

We have examined the cash records of the Joint Committee on Medico Legal Affairs of the Medical Society of Delaware and the Delaware Bar Association for the period June 1, 1958 to May 31, 1959.

Recorded receipts were traced to deposits in bank and canceled checks were compared with check stubs and/or paid invoices. Cash in bank at May 31, 1959 was confirmed direct to us by

the Farmers Bank and was reconciled with the checkbook balance at that date.

In our opinion, premised on the scope of this examination, the attached statement presents fairly the cash position of the Joint Committee on Medico Legal Affairs of the Medical Society of Delaware and the Delaware Bar Association at May 31, 1959 and the results of its cash transactions for the period indicated.

Very truly yours,
HAGGERTY & HAGGERTY
Certified Public Accountants

JOINT COMMITTEE ON MEDICO LEGAL AFFAIRS

Comparative Statement of Cash Receipts and Disbursements
For the Years Ended May 31, 1959 and May 31, 1958

	Year ended May 31, 1959	1958	Increase *Decrease*
BALANCES, JUNE 1	$225.20	$170.97	$54.23
RECEIPTS:			
Legal symposium	559.00	572.75	*13.75*
	784.20	743.72	40.48
DISBURSEMENTS:			
Luncheon	285.20	295.00	*9.80*
Demonstration team	91.70	.....	91.70
Guest speakers	85.82	136.77	*50.95*
Printing & stationery	54.75	56.75	*2.00*
Registration	20.00	30.00	*10.00*
	537.47	518.52	18.95
BALANCES, MAY 31	$246.78	$225.20	$21.53

Report accepted.

PRESIDENT SHANDS: In discussion, I might say that Dr. Gordy who has been Chairman of this committee for at least two years or three years, has asked to be relieved. Dr. Metzger has now assumed the chairmanship.

DR. METZGER: The Delaware State Bar Association has also changed their representative from Judge Herrmann to Mr. Killoran, and our most recent activity was in regard to House Bill 265, which Dr. LaMotte and the Society of Undertakers were successful in having the Governor veto.

PRESIDENT SHANDS: The next is the report of the Medical Service and Public Relations Committee.

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

The following is the report of the activities of the Committee on Medical Service and Public Relations:

The committee met in Dover on March 24, 1959. The first business considered was the question posed by the AMA's Commission on Medical Care Plans. This question was:

"Acknowledging the importance of free choice of physician, is the concept to be considered as a fundamental principle, incontrovertible, unalterable and essential to good medical care without qualification?"

It was the unanimous opinion of those present that the answer to that question must be "no".

The committee voted to pursue the health information card project, started by the preceeding committee. Several sample cards have been examined by members of the committee. At the same time, an analagous committee of the County Medical Society has been at work on the same project. These two committees should have a satisfactory card agreed upon before the first of the year.

The committee has worked on the problem of a syndicated health column. Results have been disappointing to date.

A planned half-day conference for physicians about to enter practice, stressing the business aspects of medical practice was postponed because of the small number of physicians who would have been interested in such a meeting in 1959. It was felt that plans for such a meeting should be entertained for 1960.

On May 14, 1959, the chairman took part in the Career Conference at Mount Pleasant High School. It is hoped that the results of this effort will be felt in a great influx of new physicians in 1971 or 1972.

In August, at the suggestion of the committee, Mr. Morris drafted a release for the Journal AMA concerning the dedication of the Academy of Medicine and the annual meeting of the State Society to be held there in October 1959.

The committee has planned to have another meeting during the annual session in October.

Respectfully submitted,
ALLSTON J. MORRIS, M.D., Chairman
J. B. BAKER, M.D.
D. D. BURCH, M.D.
R. R. LAYTON, M.D.
J. E. MARVIL, M.D.
E. R. MAYERBERG, M.D.
J. T. METZGER, M.D.

Report was accepted.

PRESIDENT SHANDS: The next is the report of the Medicare Adjudication Committee.

COMMITTEE ON MEDICARE ADJUDICATION

You will note that there is a considerable decrease in the number of cases referred to the Committee, which is undoubtedly due to the restrictions placed upon the Medicare Program in October, 1958. We have received from the Office for Dependents Medical Care that a restoration of many of the pre-October restrictions can be expected toward the end of 1959, but do not have any specific information on the subject. It is reasonable to assume, however, that the Committee workload will increase during the coming year.

The following summary presents each case without name, but with a general summary of the problem involved, the Committees disposition, and the action of ODMC.

1. Request from surgeon for approval of fee for repair of laceration larger than those listed in the Schedule of Allowances.

Approved by Committee—accepted by ODMC.

2. Request from surgeon for approval of fee for treatment of large abscess, not adequately covered by Schedule of Allowances.

Approved by Committee—accepted by ODMC.

3. Request from surgeon for payment for two major operations performed on different dates through same incision. Medicare regulations specify that a second operation through the same incision shall be payable at 50% of the Scheduled Fee. The surgeon felt that the difficulty of the essentially unrelated operations and the fact that the use of the same incision was an elective measure justified two separate fees. The Committee referred this case for study, and concluded that the amount and type of work done did justify 100% of the allowable fee for each operation. The Committee so recommended—accepted by ODMC.

4. Request from obstetrician for compensation beyond the Schedule of Allowances for care rendered a patient developing complications of pregnancy. The Committee referred this case for study, and concluded that extra charges in this instance were not in accordance with local custom, nor compatible with the general level of Medicare Fees. The Committee recommended payment at the maximum allowable rate of the Schedule of Allowances. Accepted by ODMC.

5. Request from general practitioner for care rendered for complications of pregnancy co-incident with payment for ante-partum care. Case is now under study and has not been resolved.

Respectfully submitted,
E. R. MAYERBERG, M.D., Chairman
L. B. FLINN, M.D.
O. A. JAMES, M.D.
W. F. PRESTON, M.D.
H. W. SMITH, M.D.
G. M. VANVALKENBURGH, M.D.
R. O. Y. WARREN, M.D.

Report accepted.

PRESIDENT SHANDS: The next is the report of the National Defense Committee.

COMMITTEE ON NATIONAL DEFENSE

The Committee on National Defense did not meet and has no report to submit.

S. W. ROSE, M.D., Chairman
J. R. BECK, M.D.
L. M. DOBSON, M.D.
J. S. MCDANIEL, JR., M.D.
D. N. SILLS, JR., M.D.
A. C. SMOOT, JR., M.D.

Report Accepted.

PRESIDENT SHANDS: The next is the report of the Polio Immunization Committee.

REPORT OF COMMITTEE ON POLIO IMMUNIZATION

As requested in your letter of September 21, 1959, the following report is submitted for the Committee on Polio Immunization.

The Committee met only once, on February 3, 1959. At this time an intensified polio immunization program was outlined. Details were worked out later by telephone consultation. As a result, the following were arranged for and subsequently carried out:

1. Every physician was reminded of his responsibility of immunizing all eligible patients.
2. The State Board of Health provided poliomyelitis vaccine free.
3. The New Castle County Chapter of the National Foundation for Infantile Paralysis purchased disposable syringes and needles.
4. Special Immunization Clinics were arranged at strategic locations in each County, and these were manned chiefly by Board of Health physicians with a few volunteer physicians from the County Medical Society. Sixteen clinics were held from March through May, directed largely at the preschool child, but adults, too, were given immunizations. These Clinics were well attended.
5. Basic immunizations and booster injections were given through schools under the Immunization Program of the State Board of Education.
6. Free vaccine was made available to all Clinics and to private physicians for those patients who could not afford the usual fee.
7. An educational campaign was carried out by means of press and radio in an effort to urge every person who needed immunization to obtain it.

Respectfully submitted,
H. H. STROUD, M.D., Chairman
JAMES BEEBE, JR., M.D.
ITALO CHARAMELLA, M.D.
R. W. COMEGYS, M.D.
M. I. HANDY, M.D.
J. F. HAYS, M.D.
F. I. HUDSON, M.D.
H. T. MCGUIRE, M.D.
R. O. Y. WARREN, M.D.

Report accepted.

PRESIDENT SHANDS: The last and the new one is the report of the Committee on By-Laws. We had a feeling that the by-laws should be revised. Nothing had been done in the way of revision in a very long time. Dr. Cannon was the Chairman of the committee which consisted of Dr. Comegys, Dr. Homan, Dr. Morris and Dr. Washburn, and they have come up with some suggestions.

REPORT OF THE COMMITTEE ON THE BY-LAWS RECOMMENDATION I

It has been suggested that a new type of membership in the Medical Society of Delaware be considered for physicians in government service and industrial medicine, so that these physicians may have access to membership in the American Medical Association without having licenses to practice medicine in the state of Delaware.

Your Committee considers enactment of this proposal desirable, and suggests the following:

a. That Article III, Section 1 be amended to read: "This Society consists of (a) active members, (b) associate members, (c) honorary members."

b. That a new Section 3 of Article III be added, to read: *Associate Members*: Associate members may be members of the medical profession on duty with the Armed Forces of the United States, governmental service at any level or those engaged in the practice of Industrial Medicine. Associate

members have all rights and privileges of active members, and must be members in good standing of a component county medical society.

c. "That all sections of Article III following the above Section 3 be renumbered in sequence."

d. "That the present Section 6 of Article III be amended to read: " . . . each active and associate member shall pay as annual dues to the Society, $50.

The Committee recommends adoption of this portion of the report.

SECRETARY CANNON: Shall we take these up separately, Mr. President?

PRESIDENT SHANDS: I think we should.

DR. MCGUIRE: I will move that we adopt the first recommendation.

DR. WASHBURN: Let me call attention to page 38 of the by-laws:

"The House of Delegates may amend these by-laws at any annual session by unanimous consent providing the motion or resolution to amend was introduced the day before the amendment was adopted, and provided further, that at least 25 members of the House are present and voting when the amendment was adopted. In the event of a dissenting vote the amendment shall lie over for the action—"

It does say the subsequent annual meeting. I thought it referred to something else.

PRESIDENT SHANDS: The dissenting vote. That means one vote.

DR. WASHBURN: May I suggest that to expedite this, you ascertain if not necessarily by the cumbersome procedure of a motion and a second as to each one, but in the absence of dissent we agree that we accept a given thing. We can accelerate and speed the procedure so that in the end we will be in a position to say we have adopted or we have not.

The motion was made, seconded and carried.

PRESIDENT SHANDS: Is there any discussion or dissension as to this first recommendation, which has to do with associate membership? This has been carefully gone into and has been recognized by the A.M.A. I don't think there is anything controversial. If there is no dissenting word, we will assume that has been passed.

Recommendation I was accepted.

SECRETARY CANNON: The second by-law change has to do with legalizing Mr. Morris' status.

RECOMMENDATION II

It has been suggested that the authority of the Council to engage an executive secretary and staff be written into the By-Laws.

Your Committee considers enactment of this proposal desirable, and suggests the following:

a. That Article V, Section 1 be amended to read: "The executive officers of the Society are the President, Vice-President, President-elect, Secretary, Treasurer, and Executive Secretary. The executive secretary shall be a member ex-officio without vote of all standing and special committees. He shall not be subject to the rules of qualification, election, and tenure that apply to other officers within these By-Laws.

b. That in Article VII, Section 1, an item 4, be to read: "The Council shall authorize the employment and define the duties of the executive secretary. The executive secretary shall be responsible for the administration and duties of the staff."

The Committee recommends the adoption of this portion of the report.

PRESIDENT SHANDS: This simply legalizes what Mr. Morris has done during the last several years, and it is in order.

Recommendation II was accepted.

RECOMMENDATION III

It has been suggested that efficiency of administration of the Society would be improved by having the terms of the executive officers and standing committees end at the close of the annual meeting.

The Committee considers enactment of this proposal desirable, and suggests the following:

a. That the final sentence of Article V, Section 3 be amended to read: "All executive officers shall assume office at the conclusion of the annual meeting, and shall serve until the corresponding session of the following annual meeting."

b. That Article XI, Section 4, be amended to read: "The members of standing committees shall be elected annually by the House of Delegates to serve one year terms, beginning at the final session of the annual meeting and terminating at the corresponding session of the following annual meeting."

The Committee recommends the adoption of this portion of the report.

SECRETARY CANNON: That means Dr. Shands will be denied part of a year, but the subsequent officers and committees will serve for the year corresponding to the annual meeting.

PRESIDENT SHANDS: This has a lot of merit and I very strongly feel that it is a good recommendation, that the President or officers of a committee work up to an annual meeting, then a new group should take over. In the past we had the annual meeting and then the officers continued on until the first of the year. There is a period there, almost a vacuum period, where the old President may not want to do something because the new President is coming in. I feel it would make it a much more effective organization if we do it this way.

Recommendation III was accepted.

RECOMMENDATION IV

It has been suggested that the duties of the President be redefined to include authority to act as spokesman for the Society, and to execute such contracts and agreements on behalf of the Society, under the authority of the House of Delegates, as may be required.

The Committee considers enactment of this proposal desirable, and suggests the following:

"That Article V, Section 6 be amended to read: "The President shall be the chief executive officer of the Society. It shall be his duty to preside at all general meetings of the Society, of the Council and of the House of Delegates; to have general and active management of the business of the Society; to see that all orders and resolutions of the Society, House of Delegates and Council are carried into effect; to execute all contracts and agreements authorized by the Society, House of Delegates or Council, to make such appointments of personnel as are authorized and to act as official spokesman of the Society; to deliver an address at the annual session at such time as may be arranged; to act as the real head of the profession in the state and to visit personally at least once during his term of office each component Society; to assist the Councilors in building up the component societies in making their work more practical and useful; to serve as a member of all standing and special committees; to make an annual report to the House of Delegates; and to appoint all committees not otherwise provided for."

The Committee recommends adoption of this portion of the report.

PRESIDENT SHANDS: This strengthens the President's position which is something that the President of an organization should have. It is spelled out as to his authority in what is done. Are there any discussions or comments? Is there any dissent?

Recommendation IV was accepted.

RECOMMENDATION V

It has been suggested that the Vice-President and President-elect be made members of the House of Delegates.

The Committee considers enactment of this proposal desirable, and recommends the following:

That Article VI, Section 2 be amended so that it will read: "The President, Vice-President,

President-elect, Secretary, Treasurer, and the elected Councilors.

The Committee recommends adoption of this portion of the report.

Recommendation V was accepted.

RECOMMENDATION VI

It has been recommended that the Vice-President and the Editor of the Society's Official Publication be made members of the Council.

The Committee considers enactment of this proposal desirable, and suggests the following:

That item 2 of Article VII, Section 2 be amended to read: "The President, President-elect, immediate Past President, Secrtary, Treasurer, Delegate to the American Medical Association and the Editor of the Society's Official Publication."

The Committee recommends adoption of this portion of the report.

PRESIDENT SHANDS: I think this is very much in order. It will make the Council a better organization because I think the Vice-President and the Editor of the Journal certainly should be members, as is true in most organizations.

Recommendation VI was accepted.

RECOMMENDATION VII

It has been suggested that this Committee on By-Laws more clearly define the order of precedence of the Vice-President and the President-elect.

The Committee recommends the following redefinition:

a. That the last sentence of Article VII, Section 3 be amended so that it reads: "The President shall preside at the meetings of the Council and in his absence the Vice-President shall preside and in his absence any member of the Council agreeable to it may preside."

b. That Article V, Section 7 be deleted and in its place there be added:
"Section 7 — The Vice-President shall assist the President in the discharge of his duties and shall officiate for him during his absence or at his request."
"Section 8 — The President-elect shall assist the President in the discharge of his duties and may officiate for him during the absence or at the request of the President and the Vice-President. The President-elect shall be prepared to assume the responsibilities of the presidency without delay upon the expiration of the President's term."

c. That the present Section 8 and 9 of Article V be renumbered to Section 9 and 10.

The Committee recommends adoption of this portion of the report.

PRESIDENT SHANDS: This is just simply establishing or detailing in our by-laws the relationship of the President-elect and the Vice-President to the President.

Recommendation VII was accepted.

RECOMMENDATION VIII

It has been suggested that the duties of the Councilors be redefined to include provision for their reporting to the component county medical societies of the actions of the Council.

Your Committee considers enactment of this proposal desirable and suggests the following:

That Article VII, Section 5 be amended to read: "Each elected Councilor shall be the judicial representative of this Society in the district from which he was elected. He shall inquire into the condition of the profession and endeavor to improve and increase the zeal of his component society and its members. He shall report promptly the proceedings of the Council to his component society. He shall make annual report of his work, and of the condition of the profession in his county or district to the Council prior to its annual meeting."

The Committee recommends adoption of this portion of the report.

PRESIDENT SHANDS: This one simply makes a more effective and closer-knit organization in the State so that the county societies know what the State Society Council is doing. We are hoping

that the minutes of the meetings of the State Society Council may be published, but at the same time it would be much more effective if the Councilor or one of the Councilors from each county would report to his society at the next county society meeting following the meeting of the Council.

Recommendation VIII was accepted.

RECOMMENDATION IX

It has been suggested that because of the mechanical and legal restrictions upon the prior action of the House of Delegates in placing the Society's fiscal year on an August 1-July 31 basis, that the fiscal year be returned to a calendar year basis.

The Committee has considered the reasons underlying this suggestion, and believes that enactment of this proposal is desirable.

The Committee suggests the following:
That Article X, Section 2 be amended to read:
"The fiscal year of the Society shall be from January 1st to December 31st inclusive."

The Committee recommends adoption of this portion of the report.

SECRETARY CANNON: As I understand it, we tried to change the fiscal year to correspond to the County Society's fiscal year, to more or less relate it to our annual meeting. Otherwise the financial report is actually on a nine-month basis. But we were blocked by the United States Government in this regard, because the Internal Revenue felt that as a tax-free organization we had to conform with the calendar year and not make the change unless it required elaborate application and modification. Consequently we went back to the calendar year.

Recommendation IX was accepted.

RECOMMENDATION X

The Committee believes that the organizational structure of the Medical Society of Delaware could be made more effective with the institution of certain changes to strengthen inter-committee communication, delineation of policy, development of leadership from within the profession, and the deliberating mechanisms of the House of Delegates. The Committee is aware that no amendment to the By-Laws can of itself accomplish these purposes, but believes that a mechanism can be built into the By-Laws to provide a means. For this reason, the Committee recommends the following major change in the organizational structure of the Society:

a. That a new article be added to the By-Laws, to be known as Article VIII — Commissions, and to read as follows:

"Section 1; Composition: There shall be two commissions, to be known as the Commission on Public Affairs and the Commission on Scientific Affairs. Each Commission shall be composed of the chairman of those committees of the Society whose functions are judged by the President to be primarily scientific or primarily socio-economic. All committees will be represented on one commission only, except that the Committee on Nominations and the Committee on the Budget will be represented on both. The Secretary shall be chairman ex-officio of the Commission on Public Affairs, and the Vice-President shall be chairman ex-officio of the Commission on Scientific Affairs.
Section 2; Duties: It shall be the duty of each Commission to:

1. Serve as a planning committee and committee on committees for those activities of the Society within its field of study.
2. To serve as a reference committee within its field of study for the House of Delegates.
3. To meet not less than three times each year to review and project the work of the Society within its field of study.
4. To delineate policy and program within its field of study, subject to the approval of the House of Delegates and/or the Council. This is not to limit the initiating authority of the House of Delegates or the Council.
5. To coordinate the activities of the committees within each Commission.

"Section 3; Duties of Commissions When Acting as Reference Committees: Each Commission shall hold itself available for one meeting during the week preceding the Annual Meeting, to serve as a Reference Committee for the House of Delegates. The President shall refer all resolutions to be presented to the House of Delegates to one of the two Committees, as he thinks appro priate, and each committee must report to the House of Delegates, favorably or unfavorably, upon each resolution referred to it. A majority of the members of the Commission will constitute a quorum for Reference Committee purposes.

"Any resolution to be offered before the House of Delegates must be referred first to a Reference Committee for study and report. No exception can be made to this section without the unanimous consent of the House of Delegates.

"Commissions when acting as Reference Committees may summon officers, members or employees of the Society for such information as may be needed to formulate their conclusions and recommendations.

"A member of a Reference Committee who wishes to make a minority report must refrain from signing the majority committee report and must make his intentions known to the other members of the Reference Committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates.

"Section 4; Subordination to the Council: Actions or recommendations of Commissions shall be reported to the Council at its next meeting. It shall be the duty of the Commission chairman to report the activities of his Commission to the Council. The Council shall have the right to approve or disapprove actions or recommendations of Commissions."

b. "That Article V, Section 7 be amended by the addition of the following sentence: "The Vice-President shall serve as chairman of the Commission on Scientific Affairs."

c. "That Article V, Section 8 be amended by the addition of this sentence: "The Secre-

tary shall serve as chairman of the Commission on Public Affairs."

The Committee recommends the adoption of this portion of the report.

PRESIDENT SHANDS: This is the new substance of the by-law changes in the best interests of the organization and the Society. Our committees have not been too well knit together, and personally I think this is good.

Are there any comments or questions of Dr. Cannon or Mr. Morris? They have thought about it a great deal, and this has been discussed in detail by the By-Laws Committee. How effective the operation will be will depend upon the leadership of the Secretary and the Vice-President. It would give them something very definite to do and be a very constructive part of the operations and affairs of the Society.

DR. MORRIS: I would like to ask a question about the section where it states that an individual wanting to submit a minority report should have his hands tied to some extent. What is the reasoning for this?

SECRETARY CANNON: It reads as follows:

"A member of the Reference Committee who wishes to make a minority report must refrain from signing the majority report and must make his intentions known to other members of the Reference Committee while it is in executive session and prior to hte presentation of the majority report to the House of Delegates."

I do not see that it ties his hands. It merely states his position. He doesn't sign the majority report but makes his own report after stating his intention of doing so.

PRESIDENT SHANDS: That is the way it operates with majority and minority reports in most groups, in most courts of law.

DR. DEWEES: Presumably one of the meetings of these commissions would have to be sometime fairly soon before the annual meeting of the House of Delegates. I suppose this is an administrative detail for the chairman to work out. But if resolutions have to be approved by one or the other of these commissions, except the unanimous consent of the House, the business that is going to come before the House of Delegates would have to go through one of these commissinns first.

SECRETARY CANNON: In the past, resolutions were submitted to the Council along with committee reports in advance of the anual meeting or this House of Delegates meeting. Instead of going to the Council they would now go to one of these commissions where, if there was any investigation of the resolution, or its desirability, the commission could have a hearing on it.

This is all new to me. I am sure Dr. McGuire can tell us more about reference committees and their function in relation to, say, the House of Delegates of the A.M.A. We may have very little use for this, but it provides mechanics for functioning as a reference committee.

DR. MCGUIRE: This is substantially the way the House of Delegates of the A.M.A. operates. Right now it has resolutions going in for the interim session meeting, and then these are referred by the Speaker of the House to whatever reference committee is appropriate in that particular resolution.

There is still time left open for the introduction of new resolutions that may develop as an outgrowth of those that have previously been introduced. So I would say this conforms pretty much to the National.

DR. FRELICK: This printed sheet here is not going to be part of the by-laws, or is it? In other words, is the Polio Immunization Committee at the present time a committee that is part of the by-law set-up? I think this is a committee that was appointed arbitrarily in the recent past by the President, and according to this, the chairman would be put on the reference committee. Does this mean, for example, that a new occasion would arise wherein a new committee should be formed where this chairman would automatically be put on this committee or these committees to be set up as such in the by-laws?

PRESIDENT SHANDS: I think Mr. Morris can answer that, but it would be my understanding that these would change from year to year, and this would not go in the by-laws because ten years from now we may not have all these same committes.

SECRETARY CANNON: The only fixed committees are the standing committees, and each year we appoint special committees which would be divided into these two areas.

EXECUTIVE SECRETARY MORRIS: This is something we worked out as an illustration the other night. We took the committees we now have. There is nothing official about it. It is simply an explantory supplement to the report. It is not a part of the report.

DR. WASHBURN: It seems to me there is a paragraph which makes clear that the rights of the House of Delegates are preserved. In other words, it is my understanding that members may introduce resolutions, initiate actions and things of that sort.

SECRETARY CANNON: It says:

"The duty of the Commission is to delineate policy and program within its field subject to approval of the House of Delegates and/or Council. This is not to limit the initiating authority of the House of Delegates or the Council."

PRESIDENT SHANDS: My reaction to this is that it is a step in the right direction. It may seem a little bit complicated as it is presented on paper, but it should work very simplly. I think it is something that should be tried. If, after two or three years, it does not seem to be working, the by-laws can be changed.

SECRETARY CANNON: As Mr. Morris said one time when we were going over this, "If the Secretary and the Vice-President completely fall down on their faces and don't call their commissions together, the committees will continue to operate in the same manner as they have in the past." If this is going to make it better, it is up to the Secretary and the Vice-President to do it. It may improve the lines of communication between the committees and the Council and the officers and the House of Delegates.

Recommendation X was accepted.

RECOMMENDATION XI

It has been suggested that the Committee on Scientific Work be redefined as a program committee, and the Secretary because of his chairmanship of the Commission on Public Affairs, be relieved of this responsibility.

Your Committee considers enactment of this suggestin to be desirable, and recommends the following:

That Article XI, Section 6 be amended by deleting the title Scientific Work and substituting the title Program. That the first senence of his section be amended to read: The Committee on Program consists of three elected members.

The Committee recommends the adoption of this portion of the report.

PRESIDENT SHANDS: We have never had a real functioning Program Committee, and the Committee on Scientific Work was originally intended to be the Program Committee. In the past the President has been his own Program Chairman, which has at times been rather difficult. This will set up a real Program Committee.

Recommendation XI was accepted.

RECOMMENDATION XII

The Committee recommends that the Executive Secretary be authorized to publish a new edition of the Charter and By-Laws of the Medical Society of Delaware, incorporating the amendments thereto up to and including those of 1959.

The Committee recommends adoption of this portion of the report.

The Committee recommends adoption of the report as a whole.

Respectfully submitted,
N. L. CANNON, M.D., Chairman
R. W. COMEGYS, M.D.
J. B. HOMAN, M.D.
A. J. MORRIS, M.D.
V. D. WASHBURN, M.D.

PRESIDENT SHANDS: The eleven sections have been approved, accepted, and the only action needed is on this last one, recommending that the Executive Secretary be authorized to publish a new edition.

DR. WASHBURN: I think there are two recommendations there, first, that there is an authorization to publish an edition. The other is that you must adopt a motion of this House adopting officially, the amendments that have been agreed upon.

PRESIDENT SHANDS: A motion is in order first to adopt the eleven changes in the by-laws.

A motion was made, seconded and carried to adopt the eleven changes in the by-laws.

PRESIDENT SHANDS: Now a motion is in order to authorize the Executive Secretary to publish a new edition of the charter and by-laws.

A motion was made, seconded, and carried to authorize the Executive Secretary to publish a new edition of the charter and by-laws.

The complete report of the Committee on By-Laws was accepted.

PRESIDENT SHANDS: Thank you very much. We have now completed the majority of the business of the House of Delegates meeting and I think a recess for about five minutes would be in order.

PRESIDENT SHANDS: Our next part of the program is reports of delegates and representatives. First is Dr. McGuire, who is going to report as the delegate to the A.M.A.

DR. MCGUIRE: I will try to summarize the activities of these two meetings. The annual meeting activities were reported in the Journal. The A.M.A. news carried pretty much, in detail, the activities of the House of Delegates. If I may have the privilege, I will summarize these in the interests of everyone.

The essential action of the A.M.A. House of Delegates' Atlantic City meeting June 8 to June 12 were as follows:

One, the rejection of compulsory inclusion of physicians in the Social Security program. I might interpolate here, that if there are any questions about any of these actions, I will be glad to answer them if I can.

Two, the relationship between medicine and osteopathy. You know that a special committee was appointed four years ago, whose recommendations were rejected. They came back this time with a favorable report that a joint committee of the A.M.A. and the A.O.A. begin to discuss the possibility of better relationship from the standpoint of teaching, consultation and practice of osteopathy and general medicine. Now that osteopathy is so intermingled with medical economics and all the pre-payment plans, insurance programs, and so on, it behooves us to attempt to improve or implement the practice of osteopathy. But, as you know, the A.O.A. House of Delegates and their President, at their meeting in Chicago rejected this. We are now back to where we were.

The next item was preparation for general practice, and the recommendation was made for two-year internship, eighteen months in medicine and pediatrics, six months in elected subjects, four months in O.B. and gynecology.

The next action of considerable importance was the third party plans or the report and support of Dr. John S. DeTar's Committee on the Third Party Plans. I will say more about that in a minute.

In summary, the American Medical Association believed that free choice of physicians is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or select his preferred system of medical care. The American Medical Association vigorously supports the right of the individual to choose between these alternatives.

Finally there was the election of officers. The President-elect was E. Vincent Askey, M.D., of Los Angeles; Vice-President, James S. Kenney, M.D., of New York; Speaker of the House, Norman A. Welch, M.D., of Boston; Vice-Speaker, Milford O. Rouse, M.D., of Dallas.

These were the essential activities of the A.M.A. meeting. We had the privilege of having Governor Boggs appear before the breakfast meeting of the Aces and Deuces, which is an organization within the House comprised of delegates from one and

two delegate states. This, incidentally, comprises 27 of our states because the House of Delegates is made up as the Congress of the United States by physician population, one per thousand. The South, Middle-West and most of the mountain states have only one or two. There are several that have gone to three.

I asked Governor Boggs to come down to give a little discourse on Delaware because there has seemed to be a lot of geographical ignorance. West of Harrisburg they talk about Delaware being a county in Pennsylvania, a part of Maryland or appended to the southern tip of New Jersey.

He asked me to write a speech and I said, I would rather tell him what not to say. Don't talk about socialized medicine, the Forand Bill, but talk about Delaware, I told him. Say that it was discovered by the Swedes, later the English came, then the Dutch, and it was currently run by the Irish, but he thought that was politically inappropriate. It was quite a privilege to have him come down and he gave a very friendly kind of talk that he is so facile in doing, and everyone, including the ladies who were there, were very appreciative. I, through your association, felt very privileged because he considerably inconvenienced himself to come down there, (for this 7:15 in the morning breakfast,) the night before he spoke.

The Minneapolis meeting was a development of some of the things that were inferred to at the Atlantic City meeting. Principally, they were on osteopathy and again on medical economics committee and on a further expression of the concern and distinct emphasis on the health needs of the aging and report of the Commission on Medical Care Plans, which also involved many aspects of the aged. Incidentally, Dr. Caighlin was named general practitioner of the year. He was from Farmington, Iowa.

PRESIDENT SHANDS: Are there any questions of Dr. McGuire? I think Dr. McGuire has done a splendid job and has represented us extremely well. I have several unsolicited letters from fellow members of the House of Delegates about his work which have been most complimentary.

DR. DEWEES: If I understand the situation, the the A.M.A. committee on osteopathic problems attempted to get closer cooperation and essentially rejected it.

DR. MCGUIRE: Yes. Five years ago a committee was set up by the Board of Trustees which was called the Klein Committee—because he was then President—and was formed on his urging. They have the osteopathic problem to a considerable degree in California since they have a state-supported school of osteopathy there. The Klein Committee then made a report similar to the one that was made this year. There was also a minority report by Dr. Rouse of Texas who got enough votes in the House to turn down the Klein report. The committee had spent five years—they had had men like Dr. Appel, Hugh Hussey at Georgetown—who actually sat in osteopathic groups a week at a time, went to their clinics, reviewed their textbooks and every phase of osteopathy—and the one demand they made was that the Osteopaths withdraw, discard or forget about the principle of Andrew J. Still.

This was a complete and thorough-going study of all aspects of osteopathy. In 1959 at our meeting here, the majority report of 1954 was endorsed by the House rather than rejected, and it was sent to the House of Delegates of the American Osteopathic Association, which met following our meeting in Chicago. They in turn rejected the whole thing with a considerable blast in the public press.

The reasoning for this was because we have a hospital here, physicians practicing osteopathy that have the sime rights and privileges that you have, who participate in pre-payment plans and all insurance programs, and so on. Osteopathy has now graduated from the general practitioner into the area of major surgery. Dr. Abiss knows a lot more about this aspect of the problem than I do. It is now felt that medicine could make a good contribution in the interests of the over-all public health problem and the good practice of medicine by eventually absorbing these osteopathic schools.

That was the general objective, but has been denied by the A.O.A.

DR. WASHBURN: Am I entirely wrong in my impression that a part of the reason for these overtures, on the part of the American Medical Association toward absorbing or taking into the fold the osteopathic profession, is to be found in the fact that by law in a number of states, it would be impossible to continue the old approach? Now, inasmuch as by law the osteopaths are entitled to serve on hospital staffs, and, as a matter of policy, as well as because of the conflict requiring this was it not because of laws requiring this that this action was taken by the American Medical Association?

DR. MCGUIRE: That is a part of it but now it is a matter of ethics.

DR. WASHBURN: Now, they are authorized to consult with the Board.

DR. MCGUIRE: Before, but now it is a question of whether this action of A.O.A. in rejecting it makes it illegal or unethical on our part, to consult with an osteopath or to work in an osteopathic hospital according to our code of ethics at the moment, or to teach.

Now it is being covertly circumvented because there are many physicians who are consulting and teaching and giving opinions to osteopathic hospitals and practitioners. But there is a legal and an ethical consideration.

DR. FRELICK: What is the future in relation to the Social Security status? Is there anything which this House of Delagates should do in view of the vote in the state, to keep the issue alive at a national level?

DR. MCGUIRE: Yes. I think last year a resolution was passed by the A.M.A. House to get a poll of delegates. Some of the larger delegations from states like New York, Illinois, California, have been introducing resolutions yearly. They represent 15,000 in New York, 12,000 in California, 11,000-and-some in Illinois. But the polls that have come in have been inconclusive. For instance, our own poll was not definitive.

EXECUTIVE SECRETARY MORRIS: More than half of the members voted but less than half of the members took any stated position.

DR. MCGUIRE: Then 12 or 15 took in equivocal debates and essays.

I would like to make this observation about the Reference Committee—that the Speaker of the House is a very powerful individual and it is he

who appoints reference committees. The Reference Committee to whom this business is being referred, the Medical Economics Committee—continually has rejected it. They have come back with a negative report and have had strength enough to sustain their action in the House.

All anyone can do locally is to make his feelings known. At the Atlantic City meeting there were about six hours of hearings on this thing and there were many, many vocal people, very opinionated and enthusiastic, and well informed people in favor, but they did not impress the Reference Committee. And they succeeded in not accepting this modification.

PRESIDENT SHANDS: Thank you, Dr. McGuire, very much for that informative report. Next is report of Dr. Washburn, representative of the Delaware Academy of Medicine.

REPORT OF THE REPRESENTATIVE TO DELAWARE ACADEMY OF MEDICINE

We meet today for the first time in the Delaware Academy of Medicine as remodeled and enlarged, lovely, dignified and yet functional. I have the conviction that members of the Medical, Dental and Allied professions who will be privileged to make use of the facilities to be found here will be inspired and impelled to be found worthy of the confidence and respect which is implicit in the financial support of our lay friends, without which it would not have been possible to erect this building and these facilities at this time.

It should be recorded that in this building we now house the Executive Offices of this Society, the State Dental Society and the New Castle County Medical Society. In addition, facilities are provided for the Woman's Auxiliary of the New Castle County Medical Society, the Delaware Diabetes Association and the American Cancer Society, Delaware Division.

An extensive periodical library is maintained as well as a medical and dental library.

The Academy of Medicine in cordial and close cooperation with the News-Journal Newspapers, Group Hospital and the Welfare Council has continued to conduct Health Forums for the general public.

Since the last meeting of the Medical Society of Delaware, the Health Forums have been as follows.

1. "What's New For the Diabetic" by Dr. Howard K. Root, Medical Director of Joslyn Clinic, Boston, Massachusetts.
2. "Treating your Itches, Rashes, and Eruptions" by Dr. Albert Kligman, Professor of Dermatology, University of Pennsylvania Medical School.
3. "The Turning Point in Mental Health" by Dr. William Menninger of the Menninger Foundation, Topeka, Kansas.
4. "New Drugs and the Quest For Health" by Dr. John C. Krantz, Jr., Professor of Pharmacology, University of Maryland Medical School.
5. "Headaches" by Dr. Perry S. MacNeal, Associate Professor of Clinical Medicine, University of Pennsylvania Medical School.
6. "Emotional Development and Disturbances of Childhood." by Dr. Louise Bates Ames, Director of Research at the Gesell Institute of Child Development.
7. "Life Stress and Bodily Disease" by Dr. Stewart Wolf of the University of Oklahoma Medical Center.

The first Annual Lecture on Diseases of the Chest jointly sponsored by the Delaware Antituberculosis Society and the Academy was held at the A. I. duPont Institute on March 9, 1959. Doctor J. G. Scadding of London delivered an outstanding lecture on "Sarcoidosis."

Respectfully submitted,
V. D. WASHBURN, M.D. Chairman

DR. WASHBURN: I submit this report knowing that kind words will be said elsewhere, but I feel that we, as doctors, should be very conscious of the fact that without the financial contribution of our lay friends we would not have that which we have, and we should be very grateful and officially record that fact in our transactions.

PRESIDENT SHANDS: Next come the 4 Liaison Reports.

LIAISON WITH MENTAL HEALTH ACTIVITIES

The fiscal year 1958-59 was a period of continued progress in mental health activities in Delaware. Improved physical facilities in several areas and expanded program of service are tangible evidence of advancement in this field.

In accord with the growing emphasis on the need of coordinating all community resources to meet the man-power shortage in mental health personnel as well as to increase the number of persons who may assist in a preventive program in mental health, in September, 1959, a ten week post graduate course in Psychiatry for the Family Physician was sponsored by the Delaware Chapter of the American Academy of General Practice, the Mental Health Association of Delaware, and the United States Public Health Service. Sixty-five physicians registered for the course. An additional ten to twelve physicians attended individual sessions. The lectures were opened on a non-credit basis to non-medical personnel working in various institutions and agencies in and around Wilmington. An average attendance of 112 included social workers, psychologists, registered and student nurses, personnel from the state training schools, members of the State Department of Police. There were four State policemen who attended every session.

On June 11, 1959, the new medical center and mental hygiene clinic building at the Hospital For The Mentally Retarded, Stockley, Delaware, was dedicated and named for your Liaison, the Dr. M. A. Tarumianz Medical Center. The hospital section of the building provides accommodations for 150 adult and child patients in its four separate wings. This building, including the Mental Hygiene Clinic unit, provides complete minor and major surgery facilities, a dental clinic, a radiology section, a clinical laboratory, an electroencephalography suite, a pharmacy, and other necessary ancillary services. In addition to the psychiatric and therapeutic facilities provided for the modern care and treatment of children and adults, the new medical center and mental hygiene clinic at Stockley make available research facilities for the study of the problems of the mentally retarded and training facilities for the preparation of personnel for various aspects of the care and treatment of the mentally retarded.

The medical center is already occupied by patients transferred from the former medical center at the Hospital For The Mentally Retarded.

Soon to be opened is the new acute and convalescent unit at the Delaware State Hospital. This building will provide in wards of one, two-, and four-bed rooms, accommodations for 175 mentally ill patients during the acute or convalescent stage of their illness.

The Drug Therapy-Home Care program instituted during the previous fiscal year, continues to return to normal life in the community, some patients who formerly would have required long hospitalization. During the past fiscal year 87 left the hospital on this program.

The Research Division at the Delaware State Hospital has continued to make a significant contribution in the field of medical research. The National Institute of Mental Health in April approved a grant of $25,000 for three consecutive years. This third grant to the Delaware State Hospital Division of Research makes possible a project entitled Clinical Exploration of New Psychotropic Compounds.

The Research Division of the Delaware State Hospital was host to a conference of Directors of Research in the United States, Smith, Kline, and French Pharmaceutical Company co-sponsored meeting, which was held near Wilmington, Delaware, on April 25 and 26, 1959. Twenty-five directors of research participated.

There has been continued and coordinated effort at the Delaware State Hospital to shorten the period of hospitalization for as many patients as possible. Various programs of intensive therapy in addition to psychotherapy and drugtherapy have contributed much to the success of this endeavor.

In March, 1959, the Delaware State Hospital was approved by the Board of Examiners of Graduate Nurses of the State of Delaware as "an agency for Psychiatric Affiliation for Professional Nurses." The Nursing Education program at the Delaware State Hospital is now accredited in Virginia, Maryland, and Delaware.

The Mental Hygiene Clinics at Farnhurst and at Stockley, Delaware, through the Evening Clinic, have given outpatient psychotherapy to adults during the fiscal year 1958-59. Meanwhile, the day time clinics continue to provide preventive, diagnostic, and therapeutic services in the mental health area. A total of 1,333 persons of all ages received service. Of this number 649 were new cases.

The Governor Bacon Health Center continued to serve the citizens of the State of Delaware. During the past fiscal year a total of 46 emotionally disturbed children (33 males, 13 females) were admitted for the first time for residential care. There was on readmission to the Maladjusted Children's Unit, a male child. Through the other divisions the Health Center has met other medical-social needs of Delawareans.

The Day Care Centers for severely mentally retarded children have increased in program and in number of children served.

The Wilmington Child Guidance Clinic, a privately operated agency, offers diagnostic and therapeutic services to children. Psychiatric treatment is available for children between the ages of four to sixteen years. Occasionally psychotherapy is given to children under four years of age, depending on the severity of their problems. Through casework, parents of the patients are given assistance.

A very successful Mental Health Week was observed in Delaware from April 27 to May 3, 1959. April 30th the annual meeting and luncheon of the Mental Health Association of Delaware brought together a large number of lay and professional persons interested in Mental Health. The speaker of the occasion was Dr. Francis Braceland, Superintendent of the Institute of Living, at Hartford, Connecticut. Open House was held at the Hospital For The Mentally Retarded as a part of the week's activities.

Members of the staffs of the State Psychiatric institutions and agencies as well a representative of the Mental Health Association of Delaware participated in the spring conference on the Northeast State Governments Conference on Mental Health, which was held at Hartford, Connecticut on April 8-10, 1959. This conference was under the chairmanship of your Liaison Officer. Several staff members of the Delaware State Hospital staff and representatives of the Delaware press and radio attended the Northeast States Conference on Mass Media In Mental Health Communication, held at New Haven, Connecticut, on March 17-19, 1959. The conference helped to interpret to members of the press, radio, and television some of the problems and needs of the psychiatric institutions and the role of the communications agencies in transmitting such information to the public.

While progress in mental health continues to be made in Delaware, there is still much to be done to provide adequate resources for preventive, diagnostic, therapeutic, and rehabilitative services in the mental health field. The supply of professional personnel to staff the residential and outpatient facilities available at present is too meager to do an adequate job. There is great need for more and better training facilities in the State for professional personnel. There is also the need for continued education of the public regarding the evidences of mental illness or handicap and emotional disturbance. The public must also be made more aware of the need of the psychiatric institutions and agencies for adequate funds for preventive work as well as for the treatment of patients. Medical personnel must continue in the treatment role, as that is their function. They must also seek the cooperation of all others in the community who can assist in preventing mental break-down and in identifying early signs of mental illness or emtotional disturbance. Only through cooperation of the members of the medical profession and the members of other professions and community agencies can the goal be achieved of more adequate mental health services for all who now need or may need such help.

Respectfully submited,
M. A. TARUMIANZ, M.D.

LIAISON WITH DELAWARE DIVISION, AMERICAN CANCER SOCIETY

It is with pleasure, that I report to you on the work done in Cancer, in the State of Delaware by the Delaware Division of the American Cancer Society. As the liaison officer of this society, I

have had the privilege of entering into and becoming well acquainted with the Cancer Society's activities. The most educational and enjoyable one being a work shop held in New York for The Northwestern States. The work shop was directed toward how we can obtain better contact with the medical profession and in this way have better co-operation in the proper handling of cases or suspicious cases of cancer.

I would like to break this report down into four separate headings each in turn to be discussed and elaborated. The first of these to be Professional Information to be followed in order by Public Information, Professional Services and finally Patient Services.

I PROFESSIONAL SERVICES

In 1958-1959, 1226 reprints were sent out in answer to requests by clinics and nurses. Books on cancer were supplied to The Beebe Hospital, the Kent General Hospital, the St. Francis Hospital, the Riverside Hospital, the Visiting Nurses Association and the Practical Nurses Course of the Brown Vocational School. These were used for reference and teaching purposes.

All physicians and the osteopaths in the State of Delaware received CANCER, a bulletin of Cancer progress and news. This magazine was also sent to all hospitals in the State and the Delaware Academy of Medicine.

Special Issues on Oral Cancer were sent to all the dentists in the state.

Special issues of the 7th International Cancer Progress were sent to each hospital, and a 2 volume set—"The Proceedings of the Second National Cancer Congress" were supplied to the Delaware, Memorial, Wilmington General, St. Francis, Kent General, Beebe, Milford, Nanticoke and Riverside Hospitals. These hospitals also received, "Diseases of the Colon and Rectum."

Monographs of material displayed at the annual meeting in New York and at the symposium put on for the Academy of General Practice in Wilmington, were sent to all physicians. These totaled 92 items.

Films and kinescopes were loaned to nursing schools at Milford, Memorial, St. Francis, and Delaware Hospitals. The practical nurses course at the Brown Vocational School also received them. The Staff Physicians of the Delaware and Kent General Hospitals also availed themselves of this service.

The American Cancer Society paid the expenses of 3 authorities from New York City in the field of cytology to give a Symposium at the Academy of General Practice meeting, unfortunately this was very poorly attended.

II PUBLIC INFORMATION

Physicians on the Board of the American Cancer Society met with members of various clubs and organizations and put on a total of 29 programs. Each program in addition to a medical speaker had also a timely moving picture.

To the schools of the state, 153 film showings were made and 19,932 pieces of literature supplied, along with visual aides. This program also included labor union headquarters, business and industrial houses.

The DuPont Company and the Board of Health has indefinite loan of cancer films. Both organizations report frequent showing of same to groups within their organization.

Three scholarships in Biological Science were given at the University of Delaware.

In summation 106,300 pieces of educational literature , 224 film showings to 16,950 persons and 88 film showings in "paid admission" theatres, along with a feature to 14,000 people, were accomplished in 1958-1959. 18 physicians covered the speaking engagements at clubs and organizations. There were 5 public showings of the Cytology film.

III PROFESSIONAL SERVICES

From the period September 1, 1958 through January 31, 1959 when all Detection Centers were discontinued by the American Cancer Society, there were 928 examinations made in 75 centers. Of these, 719 were repeat examinations and 209 new examinations. Of this total, 231 patients were referred to their physicians for suspicious lesions. In all there were during this time 23 suspicious smears and one positive smear. There was a total of 3 proven cases of cancer—one a breast cancer, one a retroperitoneal tumor and the other a proven case of cervical cancer found by direct smear.

The Cancer Registry was started by the American Cancer Society on February 1, 1959. 170 physicians signified their interest in participating, but to date only 93 physicians have registered 3,813 smears. To date, it is interesting to note, the State Board of Health has not registered any.

IV PATIENT SERVICE

During the fiscal year 1958-1959, 129 new applications for assistance were received. This makes a total of 252 patients receiving assistance. This assistance consisted of furnishing the following needed items necessary for the care and welfare of the cancer patient: namely drugs, hospital beds, wheelchairs, aid with hospital expenses, transportation back and forth to hospitals, homemaker service, colostomy equipment, visiting care, dressings and hospital gowns.

Respectfully submitted,
OSCAR N. STERN, M.D.

LIAISON WITH DELAWARE CHAPTER, AMERICAN HEART ASSOCIATION

As liaison between the Medical Society of Delaware and the Delaware Chapter of the American Heart Association, I should like to present the following brief report:

The program of the Delaware Heart Association as regards research, community service, and education proceeded along lines previously noted in last year's report, Five well organized research projects were supported; the Cardiac Screening Clinic at the Delaware Hospital was continued; speakers and films were supplied for lay groups; a Seminar for nurses was held under our auspices, and the outstanding authority on atherosclerosis, Dr. Irvine Page, of Cleveland, was provided for the May meeting of the New Castle County Medical Society. An exciting new project in community service, namely a Fellowship in Cardiology, was set up at the Delaware Hospital as a pilot study. It is the hope of all of us that this program can be continued.

Respectfully submitted,
EDWARD M. KRIEGER, M.D.

REPORT FROM DELAWARE ANTI-TUBERCULOSIS SOCIETY

Deaths among tuberculous victims in the state dropped slightly last year, but the number of new cases discovered rose to the highest point in three years.

A total of 172 new cases of tuberculosis were uncovered in Delaware last year, an increase of 15 cases or 9.5 per cent over 1957.

Deaths totalled 38, a decrease of eight as compared with figures for the previous year but still a gain over the 1956 figure of 31.

An estimated 200 cases of active tuberculosis exist undiscovered in the state of Delaware.

The attack on tuberculosis in the state was led last year by the mobile unit teams which took a total of 59,200 small films. Eight hundred ninty-four persons were recalled for confirmatory films, and 116 required medical follow-up. The mobile X-ray units uncovered 49 new cases of TB last year.

The mobile X-ray units are jointly sponsored by the State Board of Health and the Delaware Anti-Tuberculosis Society.

The goal of the Delaware Anti-Tuberculosis Society has been expanded to include the eradication of tuberculosis AND other respiratory diseases. With this slight change in phraseology, the Society embarks on a mission that has been touched only slightly during the past fifty years.

Widespread interest was shown in the first endowed lecture on pulmonary diseases which was conducted at the Alfred I. duPont Institute in March. The lecture was jointly sponsored by the Delaware Anti-Tuberculosis and the Delaware Academy of Medicine.

Dr. J. G. Scadding, dean of the Institute of Chest Diseases, Brompton, London, spoke on the topic, "Sarcoidosis."

Respectfully submitted,
GERALD A. BEATTY, M.D., President

PRESIDENT SHANDS: Next is the election of officers, a report of the Committee on Nominations. Dr. Frelick is the chairman of that elective committee which has met, considered, and presented a nomination for every office except the one of President-elect, made separately by the County Medical Society, which has the privilege of nominating for that year.

DR. FRELICK: The Nominations Committee nominates the officers plus the elected committee.

REPORT OF THE COMMITTEE ON NOMINATIONS

Vice President ..... Charles Moyer, M.D.
Secretary ..... Norman L. Cannon, M.D.
Treasurer ..... Charles Levy, M.D.
Representative to the Delaware Academy of Medicine ..... V. D. Washburn, M.D.

COMMITTEE ON THE BUDGET

Charles Levy, M.D.
M. A. Tarumianz, M.D.
W. C. Pritchard, MD.
T. H. Pennock, M D.
R. L. Klingel, M.D.

COMMITTEE ON MEDICAL EDUCATION

G. Barrett Heckler, M.D.
Laurence L. Fitchett, M.D.
Albert Gelb, M.D.

COMMITTEE ON PUBLIC LAWS

William O. LaMotte, Jr., M.D.
James Beebe, Jr., M.D.
J. Leland Fox, M.D.
J. S. McDaniel, Sr., M.D.
Gerald A. Beatty, M.D.

PROGRAM COMMITTEE

James T. Metzger, M.D.
John Rawlins, M.D.
James Beebe, Jr., M.D.

COMMITTEE ON PUBLICATIONS

A. Henry Clagett, Jr., M.D.
Norman L. Cannon, M.D.
M. A. Tarumianz, M.D.

COMMITTEE ON NOMINATIONS

John W. Alden, M.D.
Frank A. Jones, M.D.
James B. Homan, M.D.
G. M. Van Valkenburgh, M.D.

DELEGATE AND ALTERNATE TO THE AMERICAN MEDICAL ASSOCIATION

(two-year term)
H. T. McGuire, M.D.
L. M. Dobson, M.D.

BOARD OF MEDICAL EXAMINERS

Joseph S. McDaniel, Sr., M.D.
Andrew M. Gehret, M.D.
James Beebe, Jr., M.D.
Leslie M. Dobson, M.D.
W. Pierce Ellis, M.D.
Charles Levy, M.D.
E. Harold Mercer, M.D.
Harold S. Rafal, M.D.

Respectfully submitted,
R. W. FRELICK, M.D., Chairman
J. B. HOMAN, M.D.
J. W. ALDEN, JR., M.D.
J. S. MCDANIEL, M.D.

PRESIDENT SHANDS: You have heard the report of the Committee on Nominations. What is your desire?

(A motion was made and seconded to accept the report of the Committee on Nominations.)

PRESIDENT SHANDS: Are there any further nominations?

(There was no response.)

PRESIDENT SHANDS: All those in favor of the report being accepted and the Secretary casting a ballot for such will signify by saying "Aye". Opposed, "No".

(The motion was carried.)

PRESIDENT SHANDS: I declare them elected.

PRESIDENT SHANDS: The next is new business. There is an item regarding the addition to the Blue Cross-Blue Shield Board of Directors of representatives from Kent County Medical Society and Sussex County Medical Society. Mr. Secretary, do you wish to read this?

SECRETARY CANNON: It was pointed out to the Council that neither Kent nor Sussex County Societies have any representation on the Blue Cross-Blue Shield Board, and the Council discussed this and recommended that the House of Delegates pass the following motion:

RESOLUTION I

1. Regarding addition to the Blue Cross-Blue Shield Board of Directors of representatives from Kent County Medical Society and Sussex County Medical Society.

Whereas, the Board of Directors of Group Hospital Service, Inc., includes, and properly should include, members of the medical profession, and

Whereas, the New Castle County Medical Society is invited to send official representatives to this Board of Directors, and

Whereas, it is proper and fitting that physicians of Kent County and Sussex County also be represented on this Board of Directors.

Therefore, be it resolved that the House of Delegates of the Medical Society of Delaware ask Group Hospital Service, Inc., to provide for the appointment by the Kent County Medical Society and the Sussex County Medical Society of two physicians, respectively, to represent the medical profession of these counties on the Board of Directors of Group Hospital Service, Inc.

PRESIDENT SHANDS: Are you making a motion to adopt this, Mr. Secretary?

SECRETARY CANNON: Yes.

PRESIDENT SHANDS: Is there a second?

(The motion was seconded.)

PRESIDENT SHANDS: Now, does anyone wish to comment? Is there any discussion?

(There was no response.)

PRESIDENT SHANDS: I think it is certainly very much in the interests of the medical profession to request this. All those in favor of the resolution signify by saying "Aye". Opposed, "No".

(The motion was carried.)

PRESIDENT SHANDS: The next is regarding the Medical Examiner and a proper budget for his office. Mr. Secretary?

RESOLUTION II

Whereas, Senate Bill 265, redefining the duties of the county coroner, is, in the opinion of the Society detrimental to the medical examiner system, and a retrogressive piece of legislation, and

Whereas, the Honorable J. Caleb Boggs, Governor of the State of Delaware, has seen fit to veto this bill,

Therefore, be it resolved that the Medical Society of Delaware believes that the Governor has acted in the best interests of the public, and approves and supports this action, and

Be it further resolved, that this Society calls upon the General Assembly of the State of Delaware to provide funds adequate to operate the office of the medical examiner in an efficient and effective manner.

SECRETARY CANNON: I move that this be accepted.

PRESIDENT SHANDS: The Secretary has made this as a motion. Is there a second?

(The motion was seconded.)

PRESIDENT SHANDS: Is there any discussion? Is there anything you want to say about that, Mr. Morris?

EXECUTIVE SECRETARY MORRIS: Only that the Governor has vetoed this bill at the request of the Medical Society and three other organizations.

PRESIDENT SHANDS: Which includes the Bar Association, is that not right?

EXECUTIVE SECRETARY MORRIS: It has not been officially announced to the best of my knowledge that the Bar asked for it. The State Association of Funeral Directors asked for it. The New Castle County Medical Society asked for it, and the Citizens' Crime Commission asked for it.

PRESIDENT SHANDS: Any other comments?

DR. MCGUIRE: I just wanted to say this: We solicited the Governor's support to veto this legislation. I think that action of this body to thank him for the veto would be proper.

PRESIDENT SHANDS: All those in favor say "Aye". Opposed, "No".

(The motion was carried.)

PRESIDENT SHANDS: Now, Tom, do you want to make your motion?

DR. MCGUIRE: We have been hot on the wire of the Governor to get approval of the thing and I think it would be proper to acknowledge it. I therefore make such a motion.

PRESIDENT SHANDS: There is a motion to send the Governor a word of appreciation for what he has done. Is there a second to this motion?

(The motions was seconded.)

PRESIDENT SHANDS: All those in favor say "Aye". Opposed, "No".

(The motion was carried.)

PRESIDENT SHANDS: Our Secretary will take care of that.

The next one is concerning the two-way radio series. Mr. Secretary, will you read this?

RESOLUTION III

Whereas, the physicians of Delaware are participating in the first state-wide two-way radio network designed especially for medical education, and

Whereas, this project holds great potential for helping physicians to improve the medical care of the public, and

Whereas, these programs could not have been possible without the efforts of The Pennsylvania Hospital's continuation education program, or of Smith, Kline & French Laboratories, or of radio station WHYY, or of Dr. Fred MacD. Richardson, who has produced these programs,

PRESIDENT SHANDS: I think this is one of the best things that has been done in the State. There were about 50 at the meeting they had here, which I attended, last Tuesday, and if they can all be as good as this one, I think they are going to have a very good graduate education program. There was some difficulty, I understand, in the reception downstate, which I hope will be cleared up, and that they will have as good reception as we had here.

Wherefore, be it resolved, that the Medical Society of Delaware expresses its appreciation to The Pennsylvania Hospital, to Smith, Kline & French Laboratories, to radio station WHYY, and to Dr. Richardson and the Hartford Foundation.

SECRETARY CANNON: I move the adoption of this resolution.

PRESIDENT SHANDS: Is there a second to this motion?

(The motion was seconded.)

Any further comments or discussion?

All those in favor say "Aye". Opposed, "No".

(The motion was carried.)

PRESIDENT SHANDS: Now, are there any further resolutions?

(There was no response.)

PRESIDENT SHANDS: Any communications, Mr. Secretary?

SECRETARY CANNON: No.

PRESIDENT SHANDS: Mr. Executive Secretary?

EXECUTIVE SECRETARY MORRIS: No.

PRESIDENT SHANDS: Now, the next item is In Memoriam.

During the last year the following physicians have died. I think we might stand up as we read their names and then have a moment of silence at the end.

William N. Fenimore, M.D.
Howard N. Stayton, M.D.
E. Hughes Nutter, M.D.
James G. Spackman, M.D.
John W. Hooker, M.D.
Meredith I. Samuel, M.D.
Alfred W. Pennington, M.D.
George Howard Gehrmann, M.D.

PRESIDENT SHANDS: The next is the selection of a meeting place. Mr. Executive Secretary?

EXECUTIVE SECRETARY MORRIS: The by-laws provide that the meeting of the Medical Society of Delaware will be in Sussex County in 1960 unless this House wishes to fix another place.

PRESIDENT SHANDS: Does anybody wish to comment?

DR. MARVIL: On behalf of Sussex County, I would like to invite the Society to meet at Rehoboth Beach.

PRESIDENT SHANDS: Are there any other invitations?

DR. MCGUIRE: I move the acceptance of Dr. Marvil's invitation.

(The motion was seconded.)

PRESIDENT SHANDS: All those in favor signify by saying "Aye". Opposed, "No".

PRESIDENT SHANDS: Next is miscellaneous business. First, the Council recommends to the House of Delegates that authority be given the Council to present a distinguished Service Award to a lay person for outstanding achievements and/or leadership in the health services field at the 1960 and subsequent annual meetings. The proposal is permissive and does not require the Council to make such an award. This was discussed on two occasions, and is being done in other states. It is good public relations and I am very much in favor of it. It could be awarded at the same time that we make the award to the outstanding doctor in the state—the Distinguished Service Award. I know it may be difficult to select a suitable lay person for this award.

DR. DEWEES: Who would make the selection?

PRESIDENT SHANDS: It would have to be made and approved by the Council. Last year, in the case of the Distinguished Service Award for the physician, the recommendation was made by the Nominating Committee after the membership had been solicited and a letter sent. I would think that the same mechanism or pattern of selecting would be in order for this award.

A discussion by Dr. H. T. McGuire, Dr. V. D. Washburn, Dr. Charles Walker, Jr., Dr. R. W. Frelick, Dr. J. J. Repman and Dr. E. J. Szatkowski followed regarding the rise in Blue-Cross-Blue Shield admission rates and length of stay of hospital patients.

PRESIDENT SHANDS: I want to say a word about the meeting Thursday and that we hope to have a good attendance at the banquet. I heard from Dr. Orr and he will be here. He will arrive at 10:30 on Wednesday and will be here until Friday morning. He is to talk on his recent trip to Brazil and is supposed to be a very good after-dinner speaker. He may talk on some of the problems in medicine in Latin America as compared to some of our problems. I hope that you will all come.

There are a certain group of lay people here in Wilmington and the state, who are very much interested in problems of the aged, and I would like very much if you think that they would enjoy the afternoon meeting, to invite them to come. I would like to see the 218 seats filled.

On the original program which went out, we did not have all the titles. Dr. Bortz, who is a very excellent speaker is to talk on "The Changing Older Man," and he will start the seminar off.

Dr. Busse, chairman of the Department of Psychiatry, professor of psychiatry at Duke University, a member of the A.M.A. Committee on Aging, will talk on "Common Emotional Problems of the Aged." I have heard him talk and he is excellent. Everyone who has ever heard him talk on this subject has nothing but words of commendation for what he has to say and the way he says it.

The next speaker, Theodore G. Klumpp, is really a great person in medicine. He is president of the Winthrop-Stern Pharmaceutical Company right now, but much more than being a president of a company, he has been a very successful public health officer in Washington. He was chairman of the Hoover Commission Medical Services Task Force and is on the A.M.A. Committee on Aging. His subject is "Must Time Take Its Toll?" which will principally be on when a person should retire.

Then there is Dr. Orr, who has been interested in the aged for a long time. He is a discussant, and Dean Roberts, who is now the Executive Director of the National Society for Crippled Children and Adults, for five years was the Executive Director of the Joint Commission on the Aged, an A.M.A., American Hospital Association, I think maybe American College of Surgeons group. The discussants know quite well the problem and I think that lay people will get a lot out of it.

In conclusion I wish to say a word of thanks to you, the House of Delegates, for being so patient this afternoon. We have accomplished all the business we set out to accomplish. And if the by-laws go through, I will be your retiring officer at the end of the banquet, at which time the gavel will be passed over to Dr. Marvil, and I wish to say thank you.

At 6 o'clock, p.m., October 11, 1959, the House of Delegates meeting was adjourned.

when you see signs of anxiety-tension specify

Dartal®

dihydrochloride

brand of thiopropazate dihydrochloride

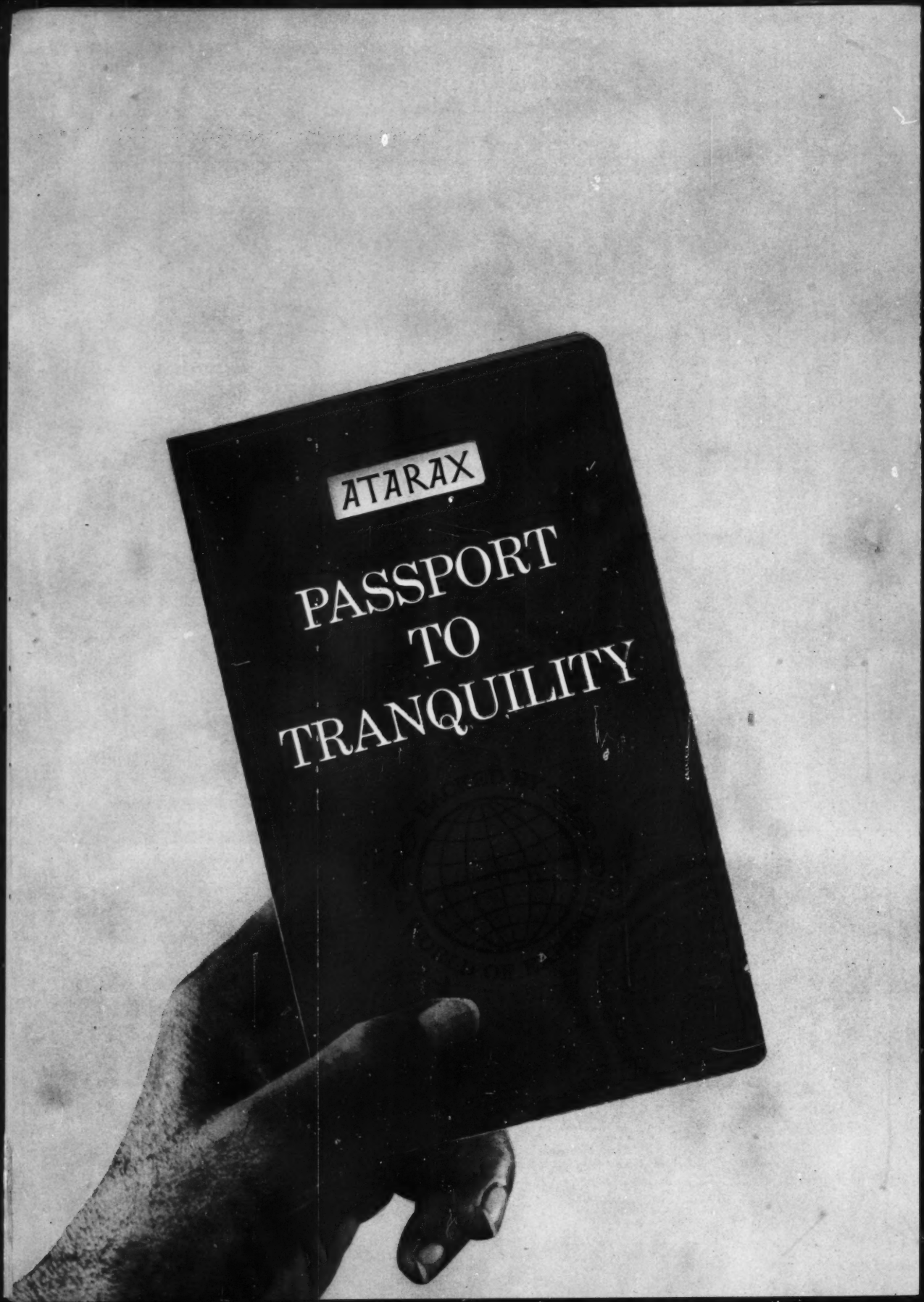
for rapid relief of anxiety manifestations

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE


ATARAX
PASSPORT
TO
TRANQUILITY

Passport

☞ **a universal record of effectiveness**

In anxiety, tension and agitation, ATARAX "... produced a more favorable state of calm and tranquility than any drug previously used."[1]

☞ **widest latitude of safety and flexibility**

No serious adverse reaction ever documented — five dosage forms and sizes

☞ **chemically distinct among tranquilizers**

Not a phenothiazine or a meprobamate

☞ **added frontiers of usefulness**

These unique benefits in specific indications

ANTIHISTAMINIC
ANTIARRHYTHMIC
ANTISECRETORY

BACKED BY A WORLD OF EXPERIENCE

Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN — 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

ATARAX®

(brand of hydroxyzine)

PASSPORT TO TRANQUILITY

Rx PFIZER

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

QUESTIONS ON THE CLINICAL USE OF KANTREX

Why should I use **KANTREX**® Injection* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics[3,4,10,12,13,17,18,20,21,23,24,25,27,30,33,35,37]

—organisms such as *Staph. aureus, Staph. albus, A. aerogenes, E. coli, H. pertussis, K. pneumoniae, Neisseria* sp., *Shigella, Salmonella* and many strains of *B. proteus.*

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

Next page, please . . . . . .

* Kanamycin sulfate injection (Bristol)

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it also?*

A A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

Q *My impression is that* KANTREX *is just another neomycin. Isn't that so?*

A Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"[14]; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

Q *You mean that* KANTREX *Injection doesn't have the nephrotoxicity of neomycin?*

A Precisely. It's true that when KANTREX Injection is used, urinary casts – even slight albuminuria or microscopic hematuria – may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

Q *Then why do you recommend reduced dosage in patients with renal impairment?*

A Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads

to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

Q *Is that why we see reports of patients developing hearing loss during* KANTREX *Injection therapy?*

A Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function – with minimal risk of ototoxicity.

Q *Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use* KANTREX *Injection in such conditions?*

A Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus, A. aerogenes* and *E. coli*, even when renal impairment is present.

Q *What are the "proper precautions" in a patient with impaired renal function?*

A The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more

is seldom required because the clinical response to KANTREX Injection is so rapid.

Q *Why do you put so much emphasis on* KANTREX'S *"rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

A There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.[1,2,3,7,8,9,11,15,16,19,21,22,26,29,32,33] Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[29]

Q *Does* KANTREX *Injection cause blood dyscrasias?*

A In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

Q *Can I administer* KANTREX *Injection in any other way than by the intramuscular route?*

A Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

Q *So you think I ought to use* KANTREX *Injection as my first choice antibiotic in staph and gram-negative infections?*

A Yes – because all evidence to date indicates that it is bactericidal against a wide range of organisms...rapid acting...does not encourage development of bacterial resistance...is well tolerated in specified dosage...and has not caused any blood dyscrasias.

KANTREX® CAPSULES

for local gastrointestinal therapy...
not for systemic infections

Q *Why can't I use* KANTREX *Capsules for systemic medication?*

A Because there is only negligible absorption of KANTREX from the gastrointestinal tract.[3,5,6,8,28,34] Thus, capsules cannot provide effective blood levels.

Q *Then what are* KANTREX *Capsules used for?*

A Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *I've been using neomycin for preoperative bowel sterilization. Why should I switch to* KANTREX *Capsules?*

A Because KANTREX has been rated as "superior to neomycin" for this purpose.[6] It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.[5,6]

Q *What advantages do* KANTREX *Capsules offer me in the treatment of intestinal infections?*

A A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella, Shigella, Staph. aureus, E. coli* and *Endamoeba histolytica.* Moreover, their use has been "remarkably free of any side effects."[31]

KANTREX®

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS

Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives": genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

DOSAGE: INTRAMUSCULAR ROUTE

Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

TOXICITY

When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION

KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

PRECAUTIONS

Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY

Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.

KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (for local gastrointestinal therapy; not for systemic medication)

INDICATIONS AND DOSAGE

For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION

Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY

KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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NIAMID*

brightens life for the aged

NIAMID gives the depressed elderly person a new sense of well-being. The family will notice a sunnier outlook, an alert interest in group activities, a renewed awareness of personal appearance, and a return of appetite. Your patient will be more cooperative and less demanding.

You can expect to see the same excellent response to NIAMID in a wide variety of depressive syndromes—acute or chronic, mild or severe, whether associated with long-standing or incurable illness, or masquerading as organic disease.

NIAMID side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. NIAMID has not been reported to cause jaundice, and significant hypotensive effects have rarely been noted.

DOSAGE: Start with 75 mg. daily in single or divided doses, and adjust according to patient response. NIAMID acts slowly, without rapid jarring of physical or mental processes. Some patients respond to NIAMID within a few days, but for full therapeutic benefit, most require at least two weeks. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

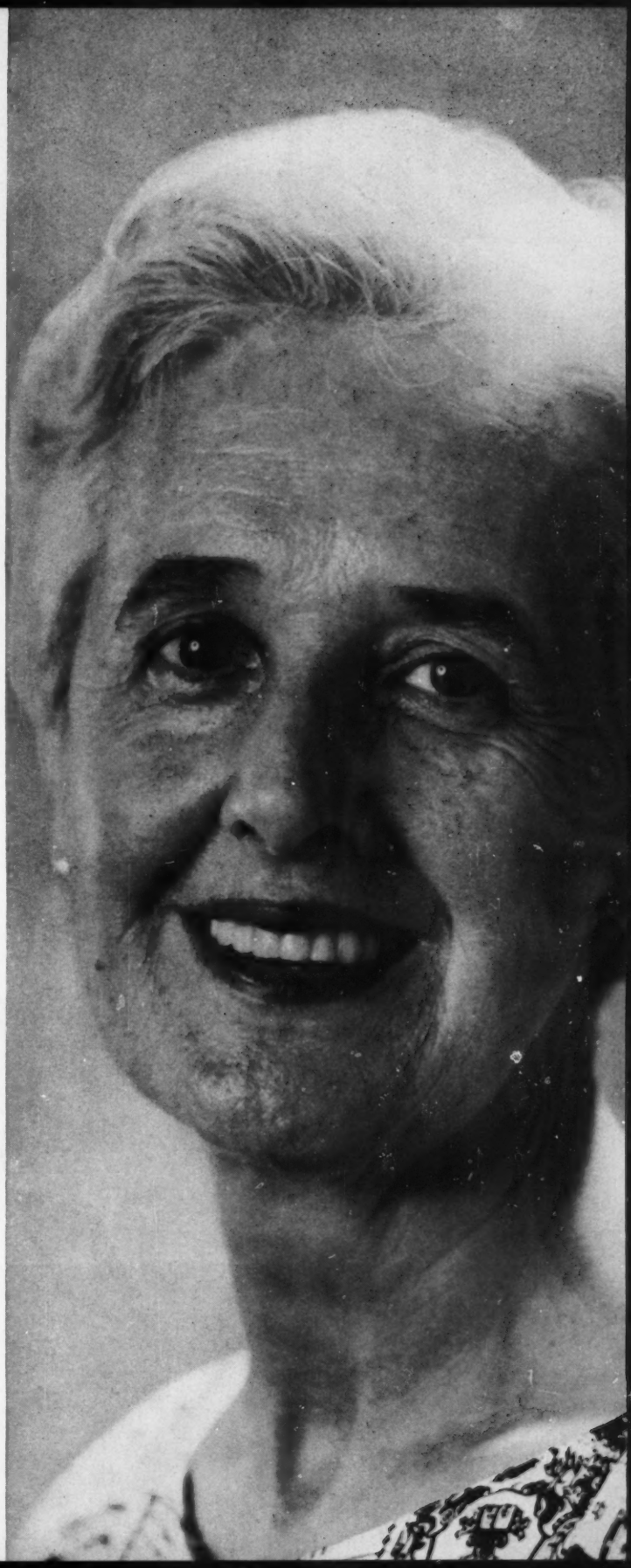
Complete references and a Professional Information Booklet giving detailed information on NIAMID *are available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

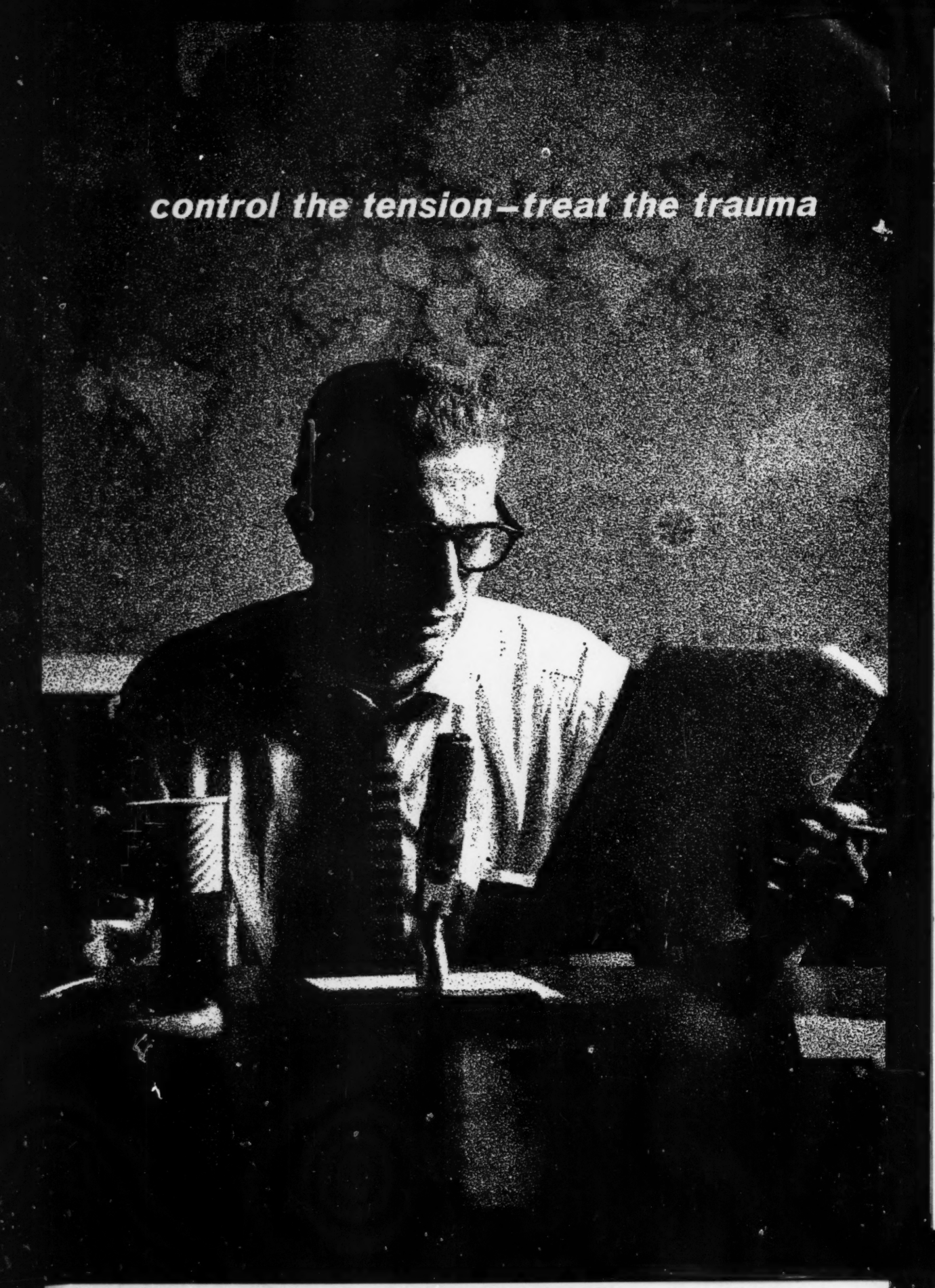
NIAMID

the mood brightener in geriatrics

*Trademark for nialamide

Pfizer *Science for the world's well-being™*




control the tension–treat the trauma

...Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and...

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Because of individual variation in the intensity of stimuli in gastrointestinal disorders, adequate dosage for optimum control may be expected to vary as well. The dosage strengths of PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.
PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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Synonyms for Pain Relief...

'TABLOID' 'EMPIRIN' COMPOUND®

Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½

'TABLOID' 'EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

No. 1
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ⅛

No. 2
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ¼

No. 3
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ½

No. 4
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. 1

*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

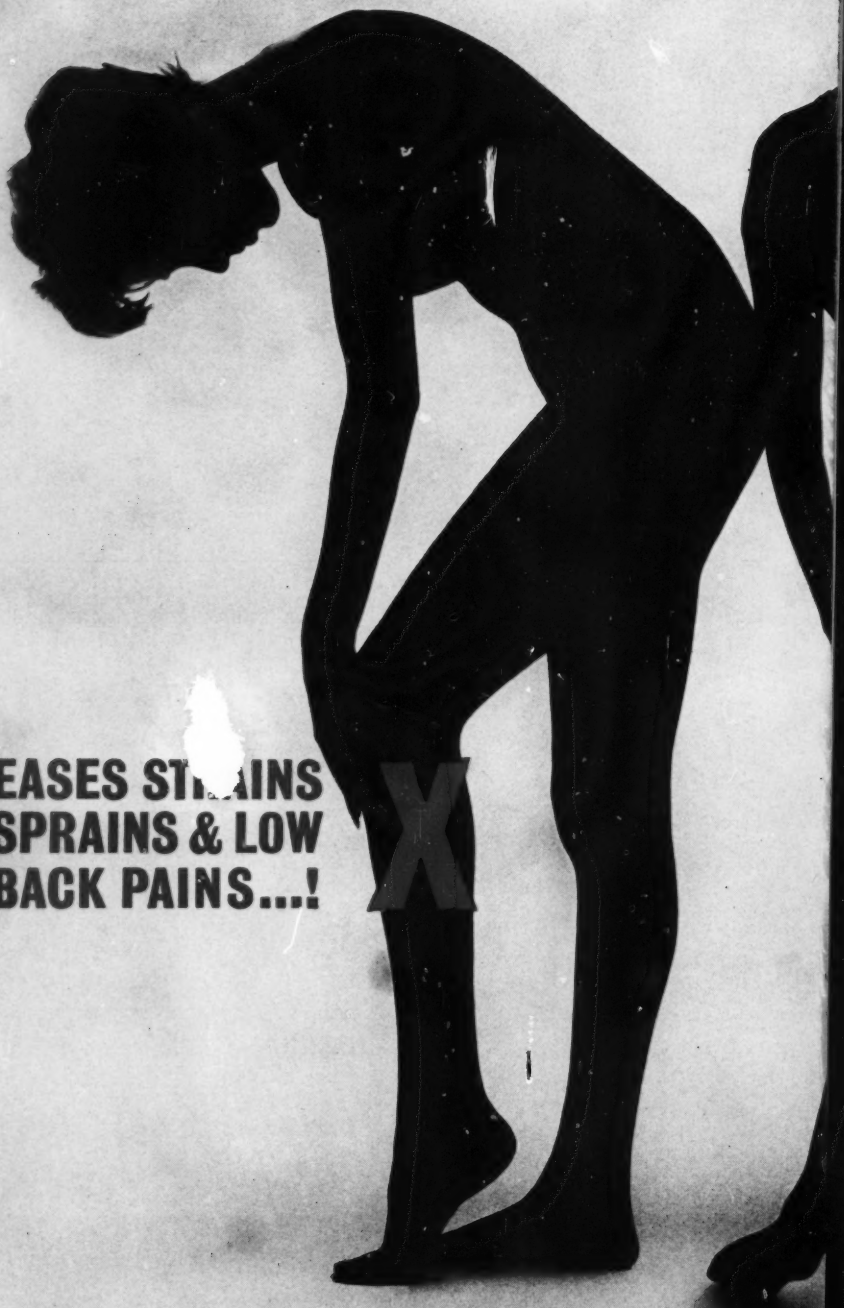
IN
simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis/bursitis

relief of pain of all degrees of severity up to that which requires morphine

AND IN
fevers
dry, unproductive coughs

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

ANNOUNCING SCHERING'S NEW MYOGESIC[X]



RELA™ EASES STRAINS SPRAINS & LOW BACK PAINS...!

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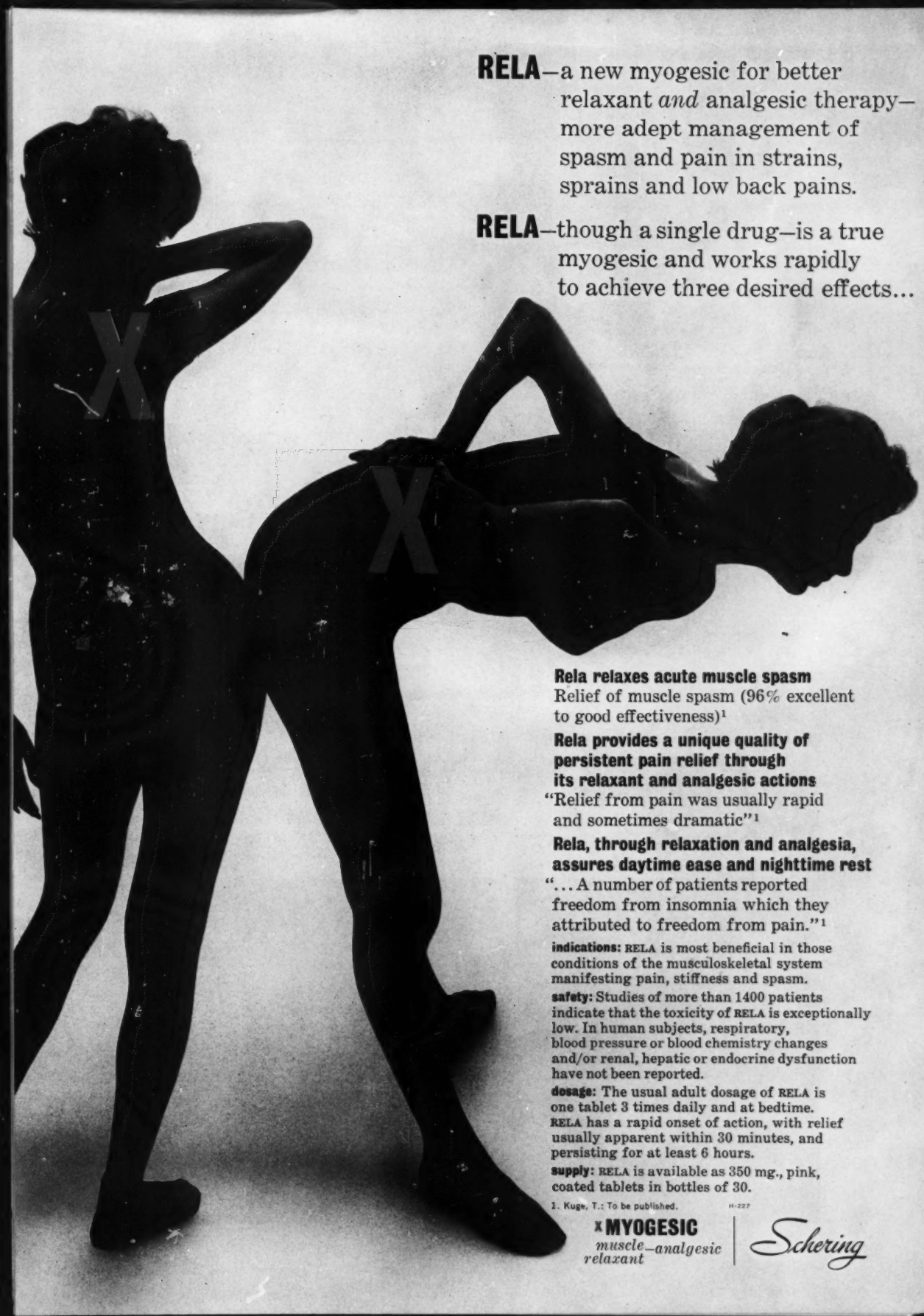

RELA—a new myogesic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogesic and works rapidly to achieve three desired effects...

Rela relaxes acute muscle spasm
Relief of muscle spasm (96% excellent to good effectiveness)[1]

Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest
"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

safety: Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.

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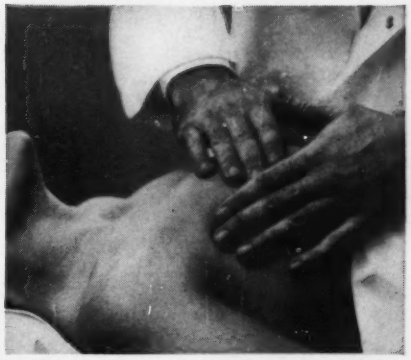
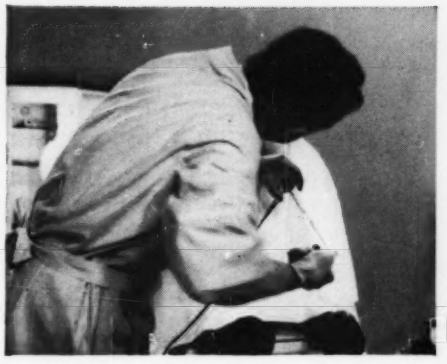
MYOGESIC
muscle-analgesic relaxant

Schering





MANY CANCERS ARE CURABLE... NOW. These are words of hope for the thousands of cancer patients who see their physicians *in time.*

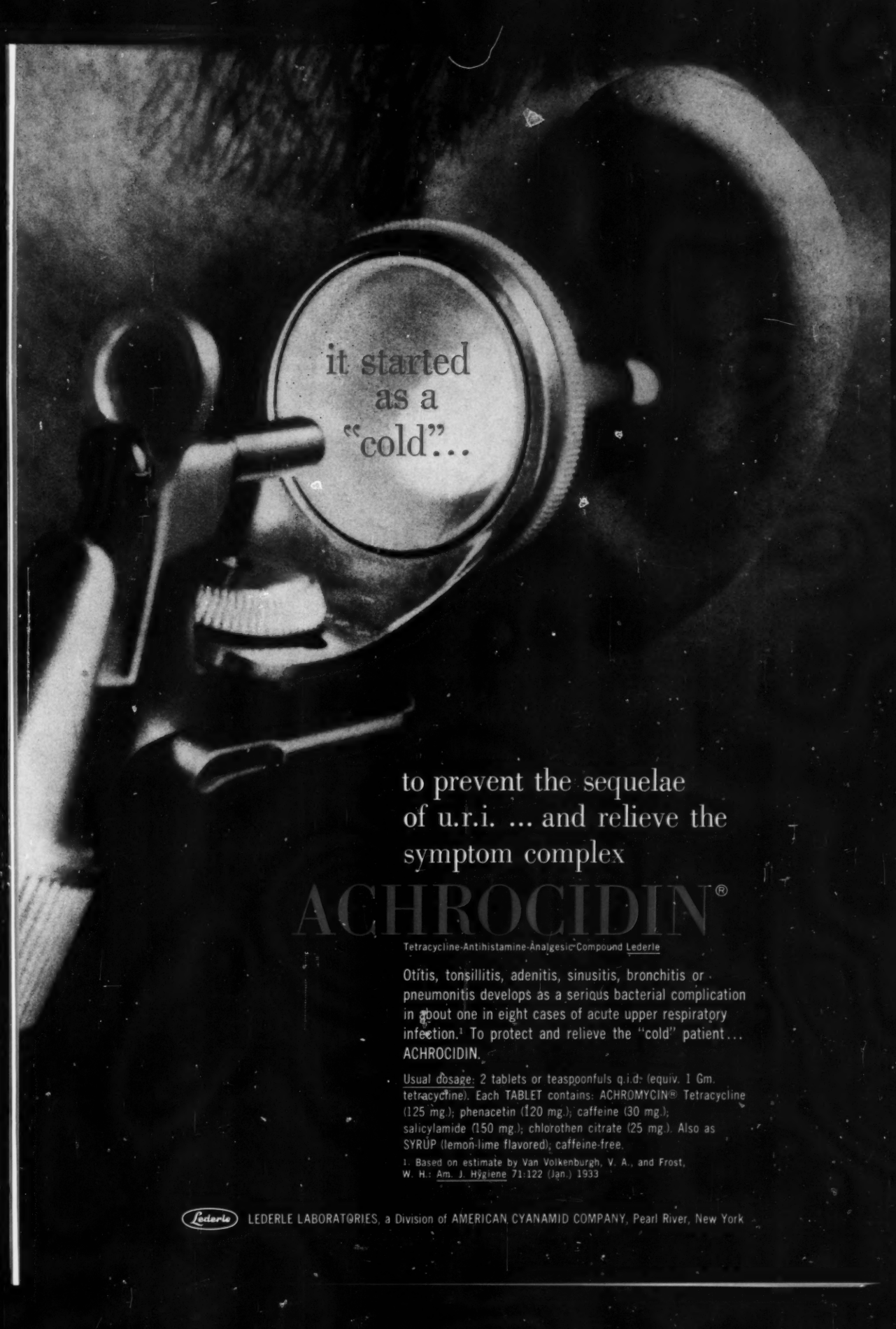
Tremendous gains can be made . . . *now* . . . in three of the most common cancer sites: breast, cervix, rectum. The annual health checkup can often detect early cancers in these sites at a time when *presently available* methods of treatment can effect many more cures than are being achieved today.

The American Cancer Society, therefore, in its broad public education program, emphasizes the importance of annual physical examinations for all adults.

Together an alerted public and the medical profession can win a major victory over cancer . . . *now.*

AMERICAN CANCER SOCIETY

DELAWARE CHAPTER, AMERICAN CANCER SOCIETY
DELAWARE ACADEMY OF MEDICINE
WILMINGTON, DELAWARE



to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Tetracycline-Triple Sulfa Combination (TETREX® c̄ T/S) in the Treatment of INFECTION

It is generally agreed that it is ideal to withhold antibiotic and chemotherapeutic drugs until after sensitivity tests show which antibacterial agent will be most effective. But very often, in actual practice, the physician knows that delay in starting antibacterial treatment may be detrimental to the welfare of his patient. He must then select the therapy to meet the most serious and immediate threats to the patient.

Why Combination Therapy?

Certain infections do not respond as well to a single agent as to a combination. *Hemophilus influenzae* infections, which are frequent in children, are a particularly serious threat to infants and children up to about 3 or 4 years of age since they have not yet built up any appreciable immunity. Serious complications such as influenzal pneumonia, empyema, or meningitis may develop, especially in this age group. In fact, except for those periods when meningococcal meningitis is epidemic, *H. influenzae* is the most frequent cause of meningitis.[1] This gram-negative organism is highly susceptible both to the tetracyclines and to the sulfonamides. Even in severe infections, therapeutic failure can be virtually eliminated by giving sulfonamides plus tetracycline.[1] These two agents together constitute the treatment of choice, and give better results than either alone.[2]

Sulfonamides remain the drugs of choice for all meningococcal infections, including meningitis. They readily penetrate the blood-brain barrier and pass into the cerebrospinal fluid in good concentrations.[3] In treating overwhelming meningococcal infections, and complicating infections of the upper respiratory tract caused by other organisms, the addition of tetracycline to sulfas can be valuable.[4]

In recent years the sulfonamides have again been prescribed more and more frequently. In certain serious infections, better results can be obtained with a combination of antibiotic and sulfonamide than with either drug alone (e.g., severe pneumococcal pneumonia or pneumococcal meningitis[5]). Furthermore, mixed infections, to which young children are particularly susceptible, often respond only to combination therapy such as tetracycline with sulfonamides (TETREX c̄ T/S).

Why Triple Sulfas?

Some sulfonamides, though therapeutically useful, frequently crystallize and cause renal damage. Sulfonamide mixtures are designed to prevent this effect. It is known that different substances can coexist in solution without interfering with each other's solubility. In such a solution each component behaves as if it alone were present. Thus, a much larger total amount of sulfonamide can exist in the urine without precipitating if a mixture is administered than if the same amount of only one compound is given.

Similarly, there is less danger of hypersensitivity with mixtures. The incidence of sensitization varies directly with the dosage and is limited to the particular sulfa given. Simultaneous use of several sulfa compounds, each in partial dosage, tends to keep each drug below its own sensitization level.[3] As with all sulfonamides, it is advisable to check for possible blood dyscrasias, rash, or renal toxicity during extended administration.

TETREX c̄ T/S, by combining only 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine, practically eliminates serious renal damage and sensitization reactions due to sulfonamides while retaining the therapeutic efficacy of the total dose.

TETREX c̄ T/S can be administered with confidence in all severe and mixed infections due to tetracycline-sensitive and sulfonamide-sensitive organisms, including infections of the upper respiratory, urinary, and gastrointestinal tracts.

References: 1. Alexander, H. E.: The hemophilus group. In: Dubois, R. J.: Bacterial and Mycotic Infections of Man. Ed. 3, Philadelphia, J. B. Lippincott Co., 1958, p. 470ff. 2. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, pp. 1322-1323. 3. Beckman, H.: Drugs — Their Nature, Action, and Use. Philadelphia, W. B. Saunders Co., 1958, pp. 527-528. 4. Dingle, J. H.: Meningococcal infections. In: Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine. Ed. 9, Philadelphia, W. B. Saunders Co., 1955, p. 196ff. 5. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, p. 1308.

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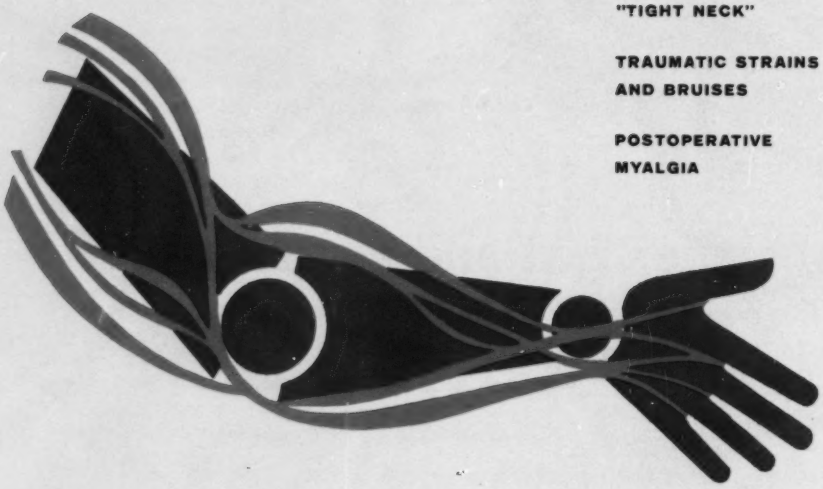

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